THE FUTURE OF HEALTH CARE FOR SENIORS: WHERE DO WE GO FROM HERE?

HEARING

BEFORE THE

SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS

OF THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

VANCOUVER, WA, DECEMBER 4, 1989

Comm. Pub. No. 101-753

Printed for the use of the Select Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

27-580 ⇆ WASHINGTON : 1990

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THE FUTURE OF HEALTH CARE FOR SENIORS: WHERE DO WE GO FROM HERE?

MONDAY, DECEMBER 4, 1989

U.S. House of Representatives,
Select Committee on Aging,
Subcommittee on Housing and Consumer Interests,
Vancouver, WA

The subcommittee met, pursuant to notice at 9:30 a.m., at the City Council Chambers, 210 East 13th Street, Vancouver, Washington, Hon. Jolene Unsoeld (acting chairwoman of the subcommittee) presiding.

Members present: Representatives Unsoeld and Wyden.

Staff present: Brian Lindberg, David Dean, Paul Elliott, Donna Levin and Liz Price.

OPENING STATEMENT OF REPRESENTATIVE JOLENE UNSOELD

Ms. Unsoeld. I am pleased to welcome you this morning to this field hearing of the House Select Committee on Aging's Subcommitte on Housing and Consumer Interests.

The title of our hearing is "The Future of Health Care for Seniors: Where Do We Go From Here?"

I am honored to be joined today by my good friend and esteemed colleague, Representative Ron Wyden, a long time member of the Aging Committee and also the Energy and Commerce Committee, which—despite the name—has a lot to do with health care issues.

He also has a unique background. His conscious efforts on both these committees on behalf of seniors, plus that background, have made him a recognized leader in Congress.

It was a delight when I came to Congress to have found him to be such a tremendous resource in helping me understand the complicated public policy issues affecting seniors, such as Medicare, abusive insurance sales practices, long-term care needs, nursing home regulations and a whole host of other issues.

We're fortunate to have Ron in Congress and very fortunate that he's here with us today. And I'd like to point out that Ron and I collaborated, in June, I believe it was, on a hearing in Portland of the Coast Guard Subcommittee. That hearing, and today's are our attempt to have a hands across the river policy. We'd like to find more that we share in common not use that river as a barrier between our two States and our two delegations.

Nearly 2 weeks ago when Congress adjourned for the remainder of this year, and just before doing so, we completed action repealing the Medicare Catastrophic Coverage Act. That repeal came less

than a year and a half after the measure was enacted and following an angry outcry from seniors all across the Nation. Congress was literally inundated with calls, letters, and visits from senior citizens who felt that the method for financing the benefits was unfair. And that the benefits themselves were unneeded and unwanted.

That fire-storm of protest surrounding the catastrophic benefits package made it clear to Congress that future expansions of the Medicare program had better have the support of those of you who are supposed to benefit from the changes.

Furthermore, the controversy over the supplemental premium demonstrated just how difficult it is to find a suitable revenue source, which is necessary if we are to expand Medicare services in this period of Federal fiscal restraint.

With the catastrophic issue behind us, this is an excellent time to reexamine the Medicare program, how it is working, how it isn't and where we might go in the future.

Today we have the benefit of hearing from some excellent individuals from both Washington and Oregon, who can speak with first-hand experience and knowledge about these issues.

As you can see from the witness list, we will hear from senior citizens as well as health care providers. We also have a panel devoted to the issue of private health insurance. All too often our Nation's elderly have been victimized by unscrupulous sales people peddling insurance and preying upon the fears that many seniors have about medical bills pushing them to destitution.

As we listen to these witnesses we need to remember that we're not just talking about the needs of today's senior citizens, but also those of tomorrow. We are an aging society. In 1950, the elderly represented only about 8 percent of our Nation's population. The figure is now close to 13 percent, and is projected to increase to more than 20 percent by the year 2030, with the aging of the baby-boom generation.

That percentage is growing because of the wonderful advances in medical technology that are permitting all of us to live longer. But this change places the enormous economic pressures on our society. Just looking at the growth in cost of the Medicare Program is evidence of the problem.

Medicare is currently the fifth largest program in the Federal budget, and it is growing at such a fast rate that unless changes are made within 25 years, it is projected that Medicare costs will exceed those of Social Security and national defense combined.

Medicare costs have grown from about $34 billion in 1980 to over $95 billion for the fiscal year just ended. And we are expected to reach in excess of $105 billion in the current fiscal year.

In effect, Medicare spending has almost tripled in 10 short years. With our rapidly aging population and medical technology creating ever more life-sustaining, but expensive, new technology, we can expect to continue to see huge increases in cost. These facts present challenges that the creators of Medicare could not have predicted some 25 years ago. And unfortunately there are few easy answers to these problems.

I want to refer to the charts that are over here before we get started, because I'd like to make a couple of points about the

graphs we have on display. First, Chart 1 shows how Medicare covers less than half of the costs of health care of the elderly. The second chart makes an important point about nursing home costs. As you can see, nursing homes consume a larger share of out-of-pocket dollars than any other category of expense. These are key points that our witnesses may refer to in their testimony.

Again, I thank you all for coming today and hope that our witnesses can enlighten all of us to some of the courses we can and should take in the years ahead. And I welcome my good friend and colleague, Representative Ron Wyden.

STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. WYDEN. Jolene, thank you very very much for that kind introduction, and it's just a pleasure to be here with you for this hearing to hear from your constituents. I want to make sure that everyone here today understands what a wonderful addition to the Northwest Congressional delegation Jolene Unsoeld has been.

It is terrific to have an advocate for older consumers, and I think many of you are aware of the tremendous work she has done on a wide variety of issues, from drift net fishing to the question of making sure we send more finished wood products around the world—rather than raw logs—and it's great to be here with her, and I think she said it very well. This is really "hands across the river day," with Oregon and Washington teaming up as we always should on matters that are important to our citizens.

I would just make a couple of quick comments, because I think Jolene said it so well, and we ought to hear from all of our witnesses.

Jolene suggested this hearing and I thought it made a great deal of sense to hear from Northwest residents right now, because in the wake of the now deceased catastrophic health care legislation, it makes sense to review where we are and where we ought to be going. And I would just say that 3 things come to my mind at this point.

First and foremost is that medical costs are gobbling up everything in sight in this country. There are no other costs that are going up like medical bills. Health care is literally today's Pac-Man, eating up everything in sight. Millions of older people now pay more out-of-pocket for their medical bills than when Medicare began in 1965. It was just half a loaf in the beginning, and every year health inflation has whittled it down even further.

The second is that we have to look at some ways to simplify this system. It is a wonder that anyone can sort out the Medicare program today, because it is so complicated, so bureaucratic. Probably every 2 or 3 weeks I get a letter or a call from someone who's a lawyer or an accountant who's in their 40s who's working with a parent on some medical bills and they can't understand Medicare. And you've got one set of rules for Part A, one set of rules for Part B, then we have the catastrophic law, medigaps, company health plans, and maybe a State workman's comp claim. We've got to simplify this bureaucratic sink-hole, so that people can understand it and make it work.

Third and last point, and this is very much on my mind today. And that is if we have learned one thing as a result of this catastrophic health debate, it is that we cannot reform our health care system piecemeal. It is now time to come up with a national strategy for universal, affordable health care, and let's get on with the witnesses and hear about how to do it.

And again, I'm just so pleased to be here with Jolene, and she's doing such a good job on so many issues. And Jolene, we're looking forward to hearing from your constituents.

Ms. UNSOELD. Thank you. Would the first panel come up, please, to those microphones. Maggie Gunn, Dr. Fay, and Mr. Gordon.

I would add that these hearings are being recorded. The record will be shared with other members of the committee and that any written testimony or contributions will be added to that record.

Now, this morning we have a couple of changes in the witnesses. Mrs. Lorene Oberheide, who is herself a cancer victim with many medical costs, has her testimony here and it's going to be read by Maggie Gunn. Mrs. Oberheide had emergency difficulty with her own health care and was not able to actually be here this morning. But her testimony is.

Maggie, would you please begin.

STATEMENT OF MAGGIE GUNN ON BEHALF OF LORENE OBERHEIDE, VANCOUVER, WASHINGTON

Ms. GUNN. I just left the side of Lorene on the way here this morning and she is feeling pretty down, right now, but was real disappointed not to be here herself and wanted Representative Wyden to know she was a former constituent of his as well, and she would have made a great witness. She's a beautiful lady.

I am Maggie Gunn. I'm with the American Cancer Society. I represent the 5-county region that Clark County is a part of in Washington State. And Lorene's testimony is as follows:

Good morning. I am here this morning to tell you what a lucky person I am. My name is Lorene Oberheide and I am 71 years old. Two weeks ago, had a modified radical mastectomy to remove cancer from my breast. Two years ago I underwent heart bypass surgery. And yes, I feel very lucky. I am alive, and most of the time I feel pretty good—I have had a few bad moments with this recent surgery because my mother died of breast cancer when I was 12 and sometimes the uncertainty can get to you—but my husband and I are enjoying our retirement and are active and able to do most of the things that we had planned all those years. We feel very fortunate indeed.

This is not the case with many of our friends, and with other Americans our age, however. A serious illness such as cancer or heart surgery takes such a toll on you—emotionally, physically and financially. I am fortunate to have the support of my husband and children and close friends, and help from American Cancer Society Reach to Recovery volunteers. I have a lot of energy and feel pretty good about my health. My husband and I have health insurance coverage through his former employer, the Aluminum Company of America, and together with Medicare, that has paid most of the expenses related to my heart surgery and the cancer.

As I mentioned, my breast cancer surgery was only two weeks ago, so I have not seen many medical bills from that, but when I had the bypass, our insurance paid all but $97 of a $40,000 bill. I am not as certain about my coverage this time. I am starting my chemotherapy treatment now and just purchased the first bottle of pills the other day for $105. Now, I paid for that myself, but I know that our health insurance plan, through ALCOA, will pay for 80 percent of all the drugs I'll use, and my husband and I will pay the rest of the bill since Medicare will not pay for these drugs.

Our private insurance coverage also pays for screening. My mother died of breast cancer and I had been wondering for years if I would have it, too. My physician and I discussed the risk factors and I always went for a physical every year and started having mammograms when I was about 63, in addition to the physical examination. My doctor actually noticed something in my breast a couple years ago which turned out to be benign, but this year I found a lump in that same area that was cancerous. The point is that I went to the doctor regularly and had the check-ups and I am alive today.

I understand from the American Cancer Society that many health insurance carriers do not cover mammography or other tests which will find cancer early. The new Catastrophic Medicare plan would have covered screening mammography and out-patient prescription drugs, but that has now been repealed. At an age when people are at more risk for a serious illness, the major insurance carrier, Medicare, will not pay for many important, life-saving procedures, and that just does not make sense.

I want to stop and say again how fortunate we have been. Sometimes we think about what would have happened if my husband's retirement benefits had not been so comprehensive. Where would we be today? There is no way that we could have afforded to pay for my bypass surgery. When I discovered the lump in my breast and the doctors scheduled surgery, I knew that my doctors did not accept Medicare as full payment for their services. But because our other insurance will pay most of what Medicare does not cover, I did not have that extra stress to deal with. It would be hard enough worrying about your surgery and whether you'll live, without fighting with insurance companies over who will pay the bills when you think that's what your insurance is there for.

I understand that many people have purchased additional insurance besides Medicare, or get benefits like we have through a retirement plan, but from talking to some of my friends, they may not be covered for many of the things that our insurance covers. Many people cannot even afford to pay the amounts that Medicare will not pay. It is also very complicated. You have to know how to read the policy and understand what's covered and what isn't. And if you don't fill out the forms right, Medicare might deny the claim. The older you get, the more involved it gets. Sometimes you just get tired of dealing with it.

I do not know everything about what has been going on with the changes in Medicare and the problems with our health care system and the rising costs, but I believe that Congress needs to be aware of the problems of real people, and make sure that we have health

insurance that will pay for the things that are needed when you become seriously ill.

My husband and I worked very hard all our lives and careful planning and luck went in out favor when we needed it. There are many more Americans in this country who are not as lucky. Thank you.

Ms. UNSOELD. Thank you, Maggie for appearing in Mrs. Oberheide's absence. I may have some questions, but let's hear from our other witnesses first. Dr. Fay.

STATEMENT OF GERALD J. FAY, MD., SPECIALIST IN INTERNAL MEDICINE, OLYMPIA, WASHINGTON

Dr. FAY. First of all I would like to thank you for inviting me here today, Representative Unsoeld, and Representative Wyden as well.

I didn't have a lot of notice about this meeting, and so what I tried to do is incorporate some problems that I've experienced in my own practice just in the last two weeks while I was preparing testimony.

And although I am listed as an expert witness, my only qualifications are I practice general internal medicine and I do sit on the Senior Health Advisory Committee for the Washington State Medical Association.

I would also like to refer to the senior citizens that are here and tell them that there is a booklet that the Washington State Medical Association puts together, it's called "The White Paper," which will give some of the statistics and facts and more details on senior health care that's available, if you'd like. You can actually get this by calling a toll-free number, which if it's okay, I'll give to the seniors now.

Ms. UNSOELD. Yes.

Dr. FAY. It is 1-800-552-0612.

Before I read my testimony, I would like to make a comment on the testimony that I just heard before, because it points out the difficulty with some of the issues in medicine.

Mammography is an important screening tool for detection of breast cancer. And the American Cancer Society has gone on record recommending that every woman over age 50 have a mammogram. The present cost of a mammography to detect one breast cancer through direct or indirect evaluation is about $22,000 per every cancer detection. This comes from an estimated $60 screening fee for every mammogram that's done, plus an estimated 3 surgical proceedings for every one true cancer that is found. That's one fact and statistics that we have to deal with as well.

I would like to just reaffirm Representative Unsoeld's statements about some of the changes that we've witnessed in the past 20 years in medical care. The explosion of treatments and diagnostic techniques have led to earlier detection in gratifying therapeutic responses to many previously untreatable conditions. New techniques for limb salvage have been developed in vascular surgery. And as you know, orthopedic joint replacement has become commonplace, as has renal dialysis.

In just the past year we've seen interventional techniques to limit heart damage in acute myocardial infarction, new radiation-free MRI scanning techniques, lithotripsy to treat renal and biliary stones without surgery, and the appearance of very expensive genetically-engineered drugs such as TPA and Erythopeoitin. Which if you haven't heard of yet, you will hear of in the future.

We are all gratified by achievements in medical care, yet they are not without their price. In the mid to late 1970s Medicare costs were skyrocketing. This was due in part to the appearance of many new medical advancements, but also to a system that had no controls on over-utilization by patient, doctor, or by hospital.

To control the rapidly-rising hospital costs Congress, in 1983, instituted the Prospective Payment system for Medicare patients based on DRGs. In addition, to control out-patient costs, a fee freeze was imposed on physicians. Despite these changes, medical costs for the elderly are still increasing. The population of Medicare enrollees is now growing at a rate of approximately 2 percent a year. Yet, health care expenditures for the elderly are growing at a rate of 15 percent a year since 1975.

By 2010 the population over 65 will start to grow dramatically, as Representative Unsoeld mentioned earlier. We can only imagine the costs.

Let's focus on how the present Medicare law affects patients' access to care and the cost of that care, first on an in-patient hospital setting, then as out-patient, and finally, prescription costs. I will conclude by making some comments on how we can improve care for the elderly, but we also need to improve affordability of health care for all.

Hospitalization. Access to hospitalization has changed for Medicare recipients since the institution of DRG reimbursement. All acute admissions are reviewed and some elective surgical or interventional procedures, such as cardiac catherization, are reviewed by prior authorization. These evaluations are carried out in Washington State by PRO-W; it's on contract with the Health Care Finance Administration.

Nationally this program has been successful in controlling the rise of hospital costs and it has reduced hospital stays from a national average from 10 days in 1983 to 8.5 days in 1986. But in addition, it has created some other problems.

Admissions for acutely ill patients must be specified by "criteria for severity of illness." Many of which are defined by abnormal test results—physicians actually carry slips of paper that list these results in determining whether a patient can be admitted to the hospital—or by abnormal physical findings. If these criteria are not met, neither the physician nor the hospital will be reimbursed by Medicare. And the physician may be fined the full costs of the hospitalization. Imagine the burden that that can present.

I present here, for your reading—I will not go over its details—but a 72-year-old woman who I saw as a patient that I admitted to the hospital very early in the DRG system, who did not fall into the criteria for severity of illness. At the time they were not making the physician responsible for the hospital bill. But just to let you know how this system doesn't always work, this patient ultimately died from the illness that she was admitted for, and on

the day that she died PRO-W sent a letter to the family telling them that she was not sick enough to be admitted to the hospital.

Despite its attempts to cut down on excessive hospital utilization, PRO-W has cost more to run than it has saved. Because of concern over possible denial, some physicians are resorting to exaggerating severity of illness in order to have patients admitted. Sometimes they'll deny admissions because patients don't fit criteria. However belatedly, its system has now changed so that patients can be admitted in an out-patient admission status to the hospital and observed for 24 hours before the decision to admit. Many of these people are acutely ill and the hospital provides full service and they are not reimbursed for that.

Also as a result of earlier discharges—5 days to get over a heart attack is what the hospital is DRG'ed for, 7 days for a stroke. Unless a patient continues to require extensive hospital care or skilled nursing they are released out to a system that's poorly equipped to help out.

I give another example of a patient I had just two weeks ago—an 82-year-old previously healthy man who came in and had a stroke followed by a heart attack. Because his stroke was very mild, he did not need to be readmitted to a rehabilitation facility and he was discharged home with visiting nurse service and chore service. However, no one could look after him at night because there was no family around. As a result the patient did not take his medications properly, he didn't eat properly, and within two weeks he was readmitted because of congestive heart failure.

Dr. Fay will be a focus review physician because a patient was readmitted within two weeks of discharge, according to the present DRG system.

In addition, Medicare does not cover the out-patient administration of IV medicines, unless the patients are placed in a skilled nursing facility. This results sometimes in longer hospital stays and without a doubt increased costs to the Medicare system.

Another example just a few weeks old. A 67-year-old woman who underwent back surgery. She was discharged. Within two weeks she came back with evidence of infection. She had an appliance called a "Steffie Plate" put in her back and as a result of that needed to be on prolonged intravenous antibiotic therapy. Ten days of that was administered in the hospital. And the plan was to send the patient, if possible, to send the patient home with a central line through which antibiotics could be administered through visiting nurse service. The present Medicare system does not allow IV medicines to be administered, therefore the patient was discharged to a nursing care facility, solely to receive intravenous antibiotics at an additional cost to Medicare of over $3,000.

The greatest impact of DRG payments will be felt in the short and long term, however, by hospital cost shift to meet expenses not covered by Medicare and Medicaid reimbursement.

Out-patient area. The vast majority of Medicare patients do not need to be admitted to a hospital within a year. As a group elderly patients, however, visit physicians twice as often as younger patients. This is related to increased costs without a doubt, but also the Medicare system for out-patient does allow easier access to primary health care. In fact Medicare age patients spend no more per-

centage-wise, although out-of-pocket expenses are more than they were, but percentage-wise they spend no more of their income on medical expenses than they did when Medicare was first enacted.

To cover increased costs in a system of capped reimbursement, some physicians have resorted to performing multiple services to make up for an inability to charge Medicare patients more, because of frozen fees. However, most patients have passed increased cost to private carriers making out-patient health care more expensive for that group.

Despite capped reimbursement, in recent years Medicare Part B costs in Washington State alone have seen dramatic increases. Seventy-six percent alone between 1985 and 1987. Some of this has been a switch in surgical procedures being done in hospitals that are now done in an out-patient setting, but that does not account for all of it.

This year I looked at 1979 statistics. The increase in physician services, fortunately, is down to an increase of only 7 percent. Now these are not fees, because fees are fixed, these are services provided.

In order to control the rising costs and redistribute physician payment in an equitable fashion, the Physician Payment Review Commission, created by Congress in 1985, recommended a resource value schedule for reimbursement. I won't go into the detail, but the previous could reimburse differently for different professional services. The greatest example is an ophthalmologist could perform an hour cataract surgery previously, and the fee that he was paid under the Medicare system would pay for me seeing a nursing home patient every month for 7 years. There wasn't any quality in the payment system. And Congress passed, recently passed this law which should help to deal with it and help to control the excessive, some excessive physician costs which have existed.

Mandatory participation in Medicare, as far as the general internist was concerned, could really affect access problems to health care. And I think elderly patients of Washington State realized this when they turned down Initiative 92 last year because of concerns that there could be limits on access to physicians if fees were frozen at the level they were and if reimbursement was mandated.

Changing reimbursement alone, however, will not in itself control the rising cost of out-patient care as to a great degree the rise has been due to a significant increase in the number of services provided. Effective evaluation of appropriateness of procedures and possible negative financial incentives to physicians and maybe even to patients may be necessary.

Let's focus on prescriptions. Most Medicare beneficiaries pay for their prescriptions for medications out of pocket. The average number of prescriptions per capita in 1987 alone was 17.7, and the cost of those prescriptions climbed from $14.41 an individual prescription in 1985 to $18.94 for prescriptions in 1988. Average Medicare enrollees will spend $336 on out-patient Medicare prescriptions. While to many patients this may not be a great burden, to others it is.

Another example here of a 67-year-old gentleman who I saw in my office last week, very fixed medical income. His prescription costs are over $130 a month, and on their fixed incomes there are

some months when he cannot take his medicine for two weeks because he can't afford to purchase them.

Now, in Washington State we have a very liberal system so that this person actually would qualify for State Assistance under DSHS, but a lot of elderly people are too proud to ask for that. And there should be something within the Medicare system to help these people out.

Concluding remarks: According to Louis B. Hays, the Acting Director of HCFA, the original intent of Medicare Insurance System when it became law in 1965, was to provide services to the elderly population by hospitals, skilled nursing facilities, and licensed physicians that were reasonable and necessary. But within the limits of financial constraints and the normal life expectancy what is reasonable and necessary treatment?

I present an example that is a difficult one. An 82-year-old woman a year ago underwent radiation therapy and chemotherapy for regionally advanced ovarian carcinoma. Her prognosis is not good from that disease alone. However, following the treatments she developed impaired renal function and was placed on dialysis. The cost to Medicare for dialysis alone, not including physician fees and her hospitalization, was $22,000 for one year.

I've presented information regarding some problems with the Medicare system that need to be addressed. Deductible coverage for high prescription costs, but in addition working with pharmaceutical companies to help defray the cost of prescriptions, especially for poor.

Development of regional half-way facilities can provide 24-hour supervision without the need of 24-hour skilled nursing care for those patients who are not ready to return to independent living once discharged from the hospital.

Revision of provider payment policies and institution of negative incentives for unnecessary procedures. Quality of care evaluation performed by physician groups for in-patient and out-patient free from legal intervention.

Approval of out-patient administration of IV medications. A need to end cost shifting from Medicare and Medicaid to private carrier sectors making affordable health care increasingly difficult for all people.

Consider long-term needs. We may need, ultimately, to consider prioritization. Across the river Oregon is dealing with this issue with Medicaid right now. Representative Wyden is aware of this as well. Dr. Kitzhaber is trying to deal with an issue where the funds do not exist for supporting the needs of the Medicaid population, and prioritization is being done there for the first time in this country, and what will happen may affect us all ultimately.

Thank you for listening.

Ms. UNSOELD. Thank you. Mr. Gordon.

STATEMENT OF BILL GORDON, EXECUTIVE DIRECTOR, OREGON GRAY PANTHERS, PORTLAND, OREGON.

Mr. GORDON. I am Bill Gordon. Mrs. Unsoeld, a good friend of mine spoke very highly of you; her name is Ann Johnson. I don't

know whether you know who she is or not. And Ron Wyden, glad to see you here again.

I am not accustomed to reading my statements. I have been involved in this for 50 years and I hope I can make my case without having to refer to a written sheet of paper.

First of all, I want to make a very brief comment relative to the issue of mammography. It so happened that I tuned in, oh, since several months back, on a program describing this Swedish health system. And what stunned me, almost, was since they had initiated their mammography program, they have cut down fatalities by 50 percent. It's practically mandatory in Sweden.

Second, I'd like to make a very brief comment to your original statement about universal access to health care, in which I have been involved for 50 years. And if I may, let me tell you a very brief story about Frances Perkins. Some of you may not know who Frances Perkins was; she was the first woman secretary in the Roosevelt administration. She had the job of Secretary of Labor. She was one of the people that was the product of the—and of course she was the one that convinced Roosevelt to at least send out a trial balloon about health care. And this is a story as was reported in the New York Times back in '35.

She went to a church meeting. It was one of those social concerns committees which many progressive churches, at any rate, have. And she spoke about the need for national health security—or national health insurance, it was generally referred to. And during the discussion a young woman got up, very irate, and she said did Mrs. Frances Perkins realize that on Page 39 of the Communist Manifesto, they also spoke about health coverage. You know what she told them? She says well, I wouldn't mind taking it off Page 39 and putting it in reality. But of course you know what happened; it actually didn't come about.

Personally I was involved in a pre-paid plan back in 1940, and at that time there were only a handful of physicians who were literally ostracized by the AMA, the American Medical Association, because they dared to set up that kind of a program. And my oldest daughter, now almost 50, as a matter of fact was born in one of those tiny little hospitals. It was the only one in Chicago that dared to stray from the course, as it were, and so I've been in this field for a long time.

It so happened that Friday, just this past Friday, I had occasion to testify before the Health Services Commission. You made reference to Dr. Kitzhaber and so on, and I decided I was going to talk about not what an adequate package ought—and as a matter of fact we don't like the use of the term priorities—because we rather would like to use the term a standard adequate package of health care, rather than trying to determine what is and what is not. No doctor wouldn't be able to say now we cannot cover you for this because it's not listed on a list of priorities.

But at any rate, let me just make some few comments about areas which you might, well, we call now "cost containment." The question of cost containment can be discussed in 2 categories. One is administrative costs. It so happened that I used the figures in an article which appeared in the New England Journal of Medicine on February 13, 1986, based on figures of 1983. So all you need to do—

as far as the percentages, I don't think they vary, but I pointed it out to the folks at this particular hearing—just add about 75 percent.

For example, do you know that the administrative costs, overall administrative costs of health care in 1983 was 22 percent. Twenty two percent, unheard of. There is no country in the world that has that kind of percent. If you take into consideration the 1500 insurance companies, and then if you add the administrative costs of Medicare, the administrative costs of—that runs into about, according to the figures in that journal it runs to over 15 percent just in those categories and that's not—does not even include, for example, private pension funds, union-run pension funds and so on. So that you have enormous possible savings.

I am frequently asked this question. Where's the money going to come from? As a matter of fact just recently Dr. Koop, the outgoing Surgeon General, spoke to the City Club. And he was also asked the same question. And he said, look, we already have money in the system, it's not a question of new monies because we're already spending about 12 percent.

And now when we come to the preventative area, there is also an area, you already alluded to many such things. I happened to pick up a program on public radio that was dealing with children in poverty. And one of the cases there was so—it's almost unbelievable—a woman, a young woman in Oakland, and this was all discussed on this program, comes into a clinic in—to the emergency care clinic with a 17-months-old infant with rickets. Now, you all know what causes rickets. It's a question of diet, right? Well, if this woman had the opportunity to get into the system at the very beginning when she was pregnant and had the care that many middle class people can afford, you can bet your bottom dollar that this would not have happened.

Let me give you another example on—you probably know what the term 'WIC' means, Women, Infants and Children. It's a supplementary dietary program to make it possible for families in poverty to be able to provide certain—now what happened to that program? It started out that they were on poverty way back when in the 1960s, as is the program for children called Headstart, it's about a shadow of what it was. I know my wife was very heavily involved in Oregon in organizing.

For example, Headstart. Let me just give you what I think is the relationship between Headstart and—because I know from personal experience what happened in Portland when my wife was running the program for the entire area, the community—and child care program.

When a child is admitted to that kind of a center, what happens is there is a parent support group, there is an opportunity for parents to find out about diet and so on. So those are the kind of things that are necessary if you're going to really affect decent preventative care. I look at it as a sociopolitical approach to the question, because if the housing is poor, if the sanitation is poor, if the—all the other things are not according to an accepted standard, you're going to have many of these kind of problems. That's where, in my opinion, you're going to have problems.

Now let me make one further comment. I don't want to take up too much of the time, of your time. On the question of the inordinate cost of health care for older people. First of all, let me say this. That anything that affects the elderly affects all of society.

Let me give you one example. I was a social worker in Chicago during the height of the Depression in the '30s. We didn't have Social Security at that time. Now, what do you think happens? If children find that their parents are in need, they have to do something about it, right? If we had had a program of that kind two things would have happened. First of all, the severity of the Depression would not have been quite as bad because a certain amount of money would have gone to the elderly people. So anything that happens to the elderly trickles down all the way. In other words, if you get—if I get benefits, my children are able to provide for their children, for my grandchildren. And that is true for everybody in this room.

So that I think let's not think only in terms, the elderly are taking all the things and we are depriving the young people. We are also grandparents. We certainly support the schools. There has been an accusation that the elderly are greedy and they take away from the mouth of the children, that's only a gimmick, an excuse that is used by certain people to keep certain kinds of programs going.

I don't want to take any more time, because I think I have addressed what I think is probably the crucial problems. Administrative costs and preventative costs. And you already alluded to many of the other things, such as the duplication of unnecessary high technology, the—what we used to call the preventative medicine; in other words you do a lot of things because you're afraid that you're going to be socked with a malpractice suit or something of this sort. Now that also could be solved if you had a universal health care system, because the costs would be spread all the way across the board.

Thank you.

Ms. Unsoeld. Excellent witnesses. I'd like to make one comment. There is in the U. S. Congress a women's issues caucus; there are some men also. But one of the things that we are going to be proposing next year is a women's health act, because there is actually very little research being done on uniquely female health problems. And you look around the room and 1 out of 9 of us women suffer from breast cancer.

Much of the research that is being done on women's health problems is done on males and then extrapolated to determine how it's going to affect females. We feel that there ought to be research directly on females.

I would like to ask any of the panelists the importance that you would place in our overall system on mammography as a preventative tool and also an attempt to bring health care costs down.

Dr. Fay. I alluded to that, too. I think that there's no doubt that mammography is a very accurate screening procedure. Its detection rate is approximately—it depends on the age group you're screening, but over age 50 is between 85 and 90 percent. It will miss some cancers.

The problem we deal with mammography is the cost and how often to do it. The American Cancer Society has recommended a yearly mammography in the hopes of picking up as many cases as possible. Unfortunately, that's a very expensive thing. Physicians are doing a yearly mammography, but most of us believe that it's too often and it's too expensive to do it yearly. We need to focus on the groups that are at high risk. Someone who has a family history of breast cancer, or someone who has a mammogram that's chancing. Sometimes they need to be done every 6 months. But yearly mammograms, at least if you look at the study of 240,000 women where they did yearly mammography for 4 years and found 4,000 breast cancer cases, if you just divide it up and they were doing screening at $50 a mammography, that's $15,000 just to screen to find one person. And then of the people they find you have to realize that often 3 out of 4 quotes calcification, which could be malignant or benign. And they need surgery and biopsy. Breast surgery is very lithogenous and as a result, the cost of that surgery has gone up to make the diagnosis of a breast cancer case in this country now about $22,000.

We can do a lot better. It will mean maybe doing mammography less often. Some women potentially could develop breast cancer, but the number would, doing less often screening in the general population, would be less and the costs would be less.

Mr. GORDON. Could I make this brief comment. Of course, I'm not an expert in the field on this position, but let me just point one thing out. We know for a fact that one case neglected triples, quadruples, quintuples in terms of subsequent costs, regardless. In other words, if you had neglected one case of an individual, by the time you are through with the total period of time that the long-term care and everything that is—it seems to me that it's probably a kind of penny foolish kind of approach to it, even though it appears to be very, very expensive, but in the long term, and I look at this same way in any other thing.

For example, we know for a fact that the child that goes to Headstart—I think they figured it was a pay out 3 to 1, something of this sort, in term of costs, I'm not even talking in terms of—so I think we need to look at the question of prevention in let's forget, let's put blinders on always on the costs, what it's going to cost. Because we know on the basis of our whole experience that in the long run it does cost us more. Only after we—there's one in Eugene for example, where the cost of neo-natal and—is just unbelievable, running into a quarter million dollars in the summer, since a half a million dollars, it seems to me that it's—I mean, we need to take a harder look at it rather than just citing figures of costs.

Ms. GUNN. I would like to say just one thing. The State of Washington has really taken the lead in this by requiring now, starting next year, that insurance companies cover the cost of mammography, and I really feel that that is the logical way to go and would like to see the rest of the country sort of follow the lead of the State of Washington and cover mammography, just consider that as part of what they do.

Dr. FAY. One last comment. None of us want to see anybody develop something that we could detect early, but in most—if we look at countries that do have national health insurance, and we just

have to look across the border north here, mammography for women over 65 is recommended every 3 years in Canada, rather than every year here, to control costs.

Ms. UNSOELD. I wanted to ask you another question, Dr. Fay. During the debate in Congress over the Medicare Catastrophic Coverage Act, it was estimated that coverage for prescription drugs that could be self-administered would help, would benefit 5.9 million people, but would cost $5 billion per year. Considering the potential benefits of drug coverage under Medicare against the costs and other priorities of the health care system for older persons, do you feel that that coverage ought to be considered a priority improvement for Medicare?

Dr. FAY. You mean the coverage of all drugs?

Ms. UNSOELD. Prescription drugs.

Dr. FAY. Oh, prescription drugs.

Ms. UNSOELD. Where would you put it in the—

Dr. FAY. Well, the issue of out—I think of out-patient intravenous drugs that could avoid admission to a nursing care facility is an absolute must. I think we have to change the way that's done. As far as other prescription coverage, I'm more in favor of a deductible, so that people don't go beyond a certain level of expenses out of pocket. And that way we can, hopefully, come to some median.

Ms. UNSOELD. Mr. Gordon.

Mr. GORDON. Yes. In the near term—of course, ultimately I think that when we do develop a health care system we may want to look at it differently—but in the near term, I was in favor of the approach that was taken in the initial catastrophic bill, that is a deductible, because we do have to bear in mind that about 15 percent of the targeted population do have some extraordinarily high drug related costs, so that I think we need to certainly provide some back up for these kind of people. And of course I'm in favor of developing the bill with the original benefits, which would include of course the drug part, and of course we already have the Medicaid buy-in, and we—but we would want—for example I think it's very important and I happen to serve on the board of a nursing home and I know what the 150 days of—what the difference between 100 and 150 days of extended care means, because it means an enormous additional cost to many of these homes who are doing, providing skilled care. Because in many of them will either have to just cost shift to patients—so that I think is a very important. Of course the spousal impoverishment I think is also important, so I would like to see the original provisions with different kind of financing. And if you want my opinion as to how we should go, I don't know if you'll agree with me, but just add a little bit to the withholding of the person who now pays 1.45 for Medicare costs and then so that the entire society—as I indicated earlier what happens to older people affects everybody and—will pick up the bill and it's not going to be that great as contrasted with the 15 percent on the targeted population. That would be my approach to the question of drugs.

Ms. UNSOELD. Representative Wyden.

Mr. WYDEN. Oh, I think all of you have done a really excellent job and I just have a couple of questions. Let me start with you,

doctor. This point about prevention is so key, because as you know, Congresswoman Unsoeld and I always talk about health care, and the fact that we really don't have health care at all, what we've got is "sick care".

Dr. FAY. Yes.

Mr. WYDEN. We just wait until somebody is flat on their back in a hospital somewhere and then we say "Holy toledo, here's a sick person" and we care for them in that acute care setting—because we have to, they're ill—and just pass all the costs on. And Medicare Part A pays the hospitals and Part B does virtually nothing in the preventative area.

What if we were to do something like this, and this is something that I have been looking at for some time. What if when an older person came on Medicare—they get a variety of mailings and information—what if we were to include in those mailings some preventative health tips, such as information about cholesterol and smoking and other preventative health tips. Accompanying that would be a kind of tear-off sheet which an older person, if they choose to, could fill out a personal health history. This tear-off sheet would allow them to go through some of the problems in the family, for example, high blood pressure or breast cancer, this kind of thing—and the next time they went in to see their physician, they would ask their physician to go over that personal health history with them. In effect, the physician could start them on a kind of preventative approach to health in terms of Medicare. Would something like that seem to you to be a step in the right direction?

Dr. FAY. I think from the standpoint of notifying patients about the importance of preventative care, it just reaffirms what the physician should be doing in his office. All my patients I do that with anyway, but it would be another source to reiterate the importance of preventative health care.

Mr. WYDEN. What I like about it is it's everybody involved. The Government would make this information available, an older patient could fill out this history if they want and then if they choose to, take it to the physician as well. And my sense is that for someone like yourself who is a geriatric practitioner, you do all this. In the vast majority of cases nothing like this goes on. Isn't that correct?

Dr. FAY. That's right.

Mr. GORDON. I'd like to add something else. We attempted during the last session of the legislature to get funding a geriatric excellence program in our medical school and our dental school, etcetera. I would submit to you that if physicians were better trained in geriatrics—and in many medical schools it's not part of the—it may be a kind of a follow up sort of thing, but that would be very, very important so the physicians would have a better idea how to deal with the geriatric issues.

The second point, Ron, that I'd like to make is it seems to me that Medicare is missing the boat. First of all, it is the agency that is responsible for 33 million people. They have more than a responsibility beyond what they're doing now, beyond the publicity, information, etcetera. And that could be done through their system. Whether they do it directly or whether they do it through the subcontractors. In our case it would be, say, Aetna, to provide this

sort—I happen to belong to Kaiser, and Kaiser gives up immense amounts of information which is—as a matter of fact, I participated in a special project which they called a falling project.

You know, many elderly people fall, and—by the way, I learned just recently, to my amazement, a lot of it has to do to the kind of medications they get. I think it was Sidney Wolff who was connected with the Nader organization who pointed that out, that there is a tendency on the part of physicians, in nursing homes and other places, to prescribe sedatives and what have you, and that is the very reason for falling.

I think there is an enormous amount of things that the Medicare organization could do, and of course, what you're suggesting is not a bad idea. Now, to what extent an older person would take the trouble to fill it out, unless you got some assistance through, oh, the whole network of organizations, advisory councils and senior centers and so on, where this sort of thing was part of their ongoing programs of education on prevention and so forth.

Mr. WYDEN. A couple of others real quickly. Doctor, late last week the White House budget office proposed an $8 billion cut in Medicare. A cut, that in my view, would just be devastating in terms of care for older people, particularly right now when we're going to have all these rate hikes with the private Medigap policies as it is. My sense is this is going to be particularly hard on low income older people, because so many of those low income older people go to facilities in the inner cities, facilities in rural areas. What's your sense of what would happen if the White House budget proposal to cut $8 billion out of Medicare works?

Dr. FAY. Well, unless the system were set up to deal with it immediately, it would create major problems. I think there's no doubt about it.

You know, there are a lot of things happening in the world, maybe we'll save some on defense spending now that the world seems to be getting along better, and some of those funds could be shifted to health care, at least temporarily, until we really come to grips with a long-term solution, which we all need.

Mr. WYDEN. You're being too logical.

Mr. GORDON. Ron, that's precisely what I was going to say. I was going to say this, 7 Stealth bombers would do the trick. We don't need them. First of all, we already know that the radar technology has developed to the point where the whole notion that there can be a—that the "stealth notion" is already obsolete. So, there would be no—nothing would happen to our defense system if we cut 7 Stealth bombers.

Mr. WYDEN. One last one, real quickly. Doctor, we're all very concerned about the problem of Alzheimer's, and this is a particularly sad and tragic illness afflicting so many older people. What's your sense of how this country is doing now in terms of dealing with Alzheimer's, both in terms of services, in terms of drugs? What's your assessment of where we are with respect to Alzheimer's and what we ought to be doing to deal with this tragedy that affects so many older people?

Dr. FAY. Of course, with a sampling of—we have 2 angles from the physician. One is his working on a solution to the problem, to

discover the cause of Alzheimer's disease, if it can. And the other is dealing with the patients.

At present, as you know, many of these people are put away into a nursing home facility somewhere and personally, although I'm not in the long-term care panel, that comes on later today, I personally feel that we need to deal with these people in a better fashion, rather than putting them in a nursing home which over the past few years, as a result of DRGs and getting sicker patients into nursing care facilities, we have sick people there and we have Alzheimer's patients there as well. Alzheimer's patients become very agitated. The tendency of the doctor and the nurses is give them a shot of a sedative and put them in the back room. That's not what we should be doing with those people.

Mr. WYDEN. Well, all of you have been terrific witnesses. We would ask you questions all morning, I think, if we had time. Thank you very much.

Ms. UNSOELD. I am going to take advantage of your expertise. So, Dr. Fay, the recent Medicare fee schedule changes that allow a consideration of the skills that the physician has, is that going to make physicians more or less likely to accept Medicare patients?

Dr. FAY. The restructured fee schedule, as far as general internal medicine is concerned, is for the better. And I never really had any intention of not taking—let's talk about it personally. I never had any intention of not taking Medicare patients.

One of the problems, if I was mandated to accept assignment, which I previously do on an individual basis, then I would have to say on the average I see three and a half Medicare patients an hour. These people need time. They're often very sick, on lots of medicines.

If I had to take assignments, I would have to see somewhere between 5 and 6 an hour, which means 10 minutes or less per patient—in the door, out the door. With the restructuring it is better for me and I—from my standpoint, and I think from general internal medicine, it's better.

How the physicians that made out very well in the previous system will react—and I'm not going into those specialties, you know what they are, all right?—how they will react to this, only time will tell.

Ms. UNSOELD. Okay. Thank you. And Ms. Gunn, will you please extend to Mrs. Oberheide our appreciation for her testimony and our best wishes to her.

Ms. GUNN. Yes, I'm going to be seeing her later and I will relay that message. And just real briefly, Congressman Wyden, I do love your suggestion about preventative—80 percent of all cancers are related to life-style, and we want to get the word out as much as we can, so I love your idea.

Mr. WYDEN. Say "hi" to your mom.

Mr. GORDON. I'd like to ask a very short question, Ron. What is the status of the waiver on the—you know what I'm talking about, Senate Bill 27?

Mr. WYDEN. Well, Bill, we could spend the whole morning talking about—

Mr. GORDON. Well, it's in limbo right now, right?

Mr. WYDEN. —that. What this issue deals with, and Dr. Fay and Congresswoman Unsoeld know, is the question of Oregon being able to receive permission from Federal Government to try an approach in Medicaid which would constitute literally a revolution in the way the Federal Government does business in the Medicaid area. It moves away from the system of mandated benefits that are now available only to a small percentage of poor people and makes a package available to all citizens. I think we're going to get the waiver in this upcoming session. But certainly there are going to be a lot of trials and tribulations before we get it done.

Mr. GORDON. Thank you.

Ms. UNSOELD. Thank you. Would the second panel please come forward?

I am reminded by the staff that we are running a little bit behind and that if we can each try to keep our remarks to about 5 minutes and then have time for questions, that if you have written testimony, it will be submitted into the record, and so if you can summarize or deviate from it as you feel appropriate to steer the conversation.

I'd like to also point out that Mrs. Grubb, who was to be with us this morning as an advocate and primary care giver for her chronically ill husband, has been required to accompany her husband, I believe he was hospitalized today. And therefore, we have, is it Nancy Gorshee?

Ms. GORSHEE. That's correct.

Ms. UNSOELD. Representing Mrs. Grubb. Would you begin, please.

STATEMENT OF NANCY GORSHEE ON BEHALF OF VIVIAN GRUBB, AGING ADVOCATE, PORTLAND, OREGON

Ms. GORSHEE. Thank you. I'm Nancy Gorshee and I am the Director of Gerontology of Providence Hospital in Portland and a personal friend of Vivian. And when Vivian was asked to testify, she called and asked, because she doesn't have time, if I would help her put on paper the words that she would like to share with you. So I offered to do that for her and thus, am here with you today.

Basically there is an interesting picture to Vivian that is important to share with everyone. Vivian is a very active person and I believe, Ron, that you know Vivian from the Portland area. She is an advocate, she's worked on senior issues for years. But she is also a wife, mother and grandmother and has been a caregiver in many settings within her own family.

She has been very happily married to her husband, Orville, for over 52 years and has been dealing with the management of his chronic care needs and illness for the last about 4 years.

It was 4 years ago that her husband, Orville, was diagnosed with Polymalasia Rheumatica, which is a painful disease that affects all of the bone joints and creates a lot of fever to manage on a daily basis.

This was their experience, their first experience of learning what—how much lack of support there is for victims of chronic illness and for their care-givers.

At that time her husband was hospitalized for 4 days and in Vivian's opinion, discharged prematurely early, due to that diagnosis

as being a chronic disease. She fought this early discharge, for his sake, however, did have to take him home. He returned to the hospital 2 days later, due to his declining condition and stayed for 3 more weeks. His chronic diagnosis thus changing to an acute diagnosis.

The new Medicare reimbursement system of DRGs as were spoken about in the last panel, did change their own plan of care. And in her opinion actually prolonged his illness.

At the end of this second hospitalization, the physician recommended that she place Orville in a nursing home. However, her goal was to take him home and when appropriate she believed that he would recuperate much better in their own home.

Orville was allocated 10 days of Medicare home care, initially personal care, or skilled nursing care, but for them that was not enough. After those 10 days, Vivian remembers feeling abandoned and alone without the help of those initial health care givers that had helped them through their problems.

She also knew where to turn to in the community and found little help. She needed help herself as she was recovering from a broken arm. And the only help available, besides that of her family, which was there as much as it could be, was the help that she could pay for. She felt she needed in-home, non-nursing assistance in the form of personal care, which was not affordable for them on the daily basis that they needed it.

She remembered the worst part of Orville's being diagnosed later, approximately 2 years later, with Alzheimer's, was that there was also no help following that diagnosis. She felt a great lack of support from all of the health care systems, the medical, community and in-home service systems. Medicare did not pay for either management of the chronic illness nor long-term care services that they needed. The Grubbs needed both services.

The Grubbs have been self-sufficient and lived most of their life in a very middle-class normal living, as Vivian would describe it. However, since Orville's illness their funds that they had saved for their retirement have indeed been dwindling.

Vivian does not have the resources in her regular monthly budget to pay for the in-home services that she asks for now. She needs respite and she'd prefer adult day care on a regular basis. Yet, they are not eligible for the public services that are available in Oregon.

As a caregiver Vivian also asks for help to keep her strong. She asks for help to keep her mentally healthy, as she feels most healthy when she is a contributor in the community. To do that, she specifically needs respite care and in Portland the cheapest respite care is about $8.50 an hour, of which she feels she could only afford approximately 1 to 2 times a week.

She also would like access to counseling service for herself. She would like help with her frustrations and fears, when she's not feeling strong. And this service needs to come to her, in her own home. There are some limited mental health services for victims, for older people, most likely her husband, but she feels that she needs that service herself. Support groups are good, but not convenient for Vivian, as most often offered in the evening without respite care provided at no cost.

Her biggest fears are about her future, as you might well guess. If Orville does eventually have to move into a long-term care facility because of his illnesses, how would she afford it. Vivian has not planned ahead and does not have long-term care insurance at this time. She worries what would be left of their resources if indeed this is to happen to him. Who would take care of her? Her children are nearby, provide as much as they can, but she fears that they are not able to provide either the financial or moral support as much as she needs now. Her daughter does live in Vancouver and last night she went over to help her mother and stayed overnight with them. But as Vivian said on the phone this morning, that it is only Vivian that can really help negotiate all the health care needs that they need right now.

She was also worried that she brought in her testimony no answers for you today, but rather just a list of problems. And she specifically asks that you help the care-givers and to urge you to also make our health care system more flexible to ensure that the real help that's needed by people for both chronic care and long-term care is achieved.

Her last words to me this morning were about her regret about not being able to be here. And one of the words she said that I thought was so sad was that as a care-giver she is not dependable. And that again, to bring across her messages I think such a poignant statement with having 2 witnesses not here today, is that we do not hear enough from the people who are most hidden, either themselves from illness, or as care-givers.

Thank you.

[The prepared statement of Vivian Grubb follows:]

MANAGING CHRONIC ILLNESS AS A CAREGIVER:

ISSUES OF CONCERN

REPRESENTATIVE JOLENE UNSOELD

REPRESENTATIVE RON WYDEN

DECEMBER 4, 1989

VANCOUVER, WASHINGTON

TESTIMONY OF VIVIAN GRUBB

CAREGIVER AND SENIOR ADVOCATE

PORTLAND, OREGON

REPRESENTATIVES UNSOELD AND WYDEN, THANK YOU FOR THE OPPORTUNITY TO TESTIFY TODAY BEFORE YOU ON THE ISSUES OF MANAGING THE CHRONIC HEALTH CARE OF MY HUSBAND. I AM VIVIAN GRUBB OF PORTLAND, OREGON. I HAVE BEEN HAPPILY MARRIED TO MY HUSBAND ORVILLE FOR OVER FIFTY-TWO YEARS. MY HUSBAND WAS DIAGNOSED WITH ALZHEIMERS DISEASE IN 1987. SINCE THEN I HAVE BECOME HIS PRIMARY CAREGIVER.

I AM A WIFE, MOTHER OF TWO, AND GRANDMOTHER OF FOUR. UNTIL MY RETIREMENT I WAS AN EDUCATOR IN OUR COMMUNITY MY RESPONSIBILITIES RANGING FROM TEACHING IN A ONE ROOM SCHOOL ROOM TO BEING A VICE PRINCIPAL IN A PORTLAND SCHOOL. I HAVE BEEN ACTIVE IN COMMUNITY CONCERNS ESPECIALLY SINCE MY RETIREMENT. I HAVE SERVED AS THE CHAIRPERSON OF THE PORTLAND MULTNOMAH COMMISSION ON AGING AND HAVE CHAIRED THE BOARD OF DIRECTORS OF O.A.S.I.S. A PUBLIC/PRIVATE SECTOR AGING INITIATIVE IN PORTLAND AND OTHER CITIES THROUGHOUT THE COUNTRY.

FOUR YEARS AGO, MY HUSBAND WAS DIAGNOSED WITH POLYMALASIA RHEUMATICA, A PAINFUL DISEASE WITH CONSTANT FEVER AND PAIN OF ALL BODY JOINTS. THIS EXPERIENCE WAS THE BEGINNING OF MY PERSONAL LEARNING ABOUT THE LACK OF SUPPORT FOR A VICTIM OF CHRONIC ILLNESS AND THEIR CAREGIVERS.

MY HUSBAND WAS HOSPITALIZED FOR FOUR DAYS, THEN IN MY OPINION, DISCHARGED PREMATURELY EARLY. I FOUGHT THIS EARLY DISCHARGE, FOR HIS SAKE, HOWEVER DID BRING HIM HOME. HE RETURNED TO THE HOSPITAL TWO DAYS LATER DUE TO HIS CONDITION AND STAYED FOR THREE MORE

WEEKS. THE NEW MEDICARE REIMBURSEMENT SYSTEM, DISCHARGING ACCORDING TO DIAGNOSTIC RELATED GROUPINGS, CHANGED OUR PLAN OF CARE AND ACTUALLY PROLONGED HIS ILLNESS.

AT THE END OF THE SECOND HOSPITALIZATION, THE PHYSICIAN RECOMMENDED THAT I PLACE ORVILLE IN A NURSING HOME. HOWEVER, MY GOAL WAS TO BRING HIM HOME WHEN IT WAS APPROPRIATE, AS I BELIEVED HE WOULD RECUPERATE BETTER IN FRONT OF OUR FIREPLACE AND WITH OUR FAMILY DOG NEARBY TO COMFORT. WE WERE ALLOCATED TEN DAYS OF MEDICARE HOME CARE, INITIALLY SKILLED NURSING THEN PERSONAL CARE FOR BATHING ASSISTANCE. THAT WAS NOT ENOUGH. I FELT ABANDONED AND ALONE, CUT OFF FROM THE HEALTH CARE PROVIDERS INITIALLY HELPING, AND NO OTHERS IN THE COMMUNITY TO TURN TO.

I NEEDED HELP THEN, AS I WAS RECOVERING FROM A BROKEN ARM, MY ARM IN A CAST. THE ONLY HELP AVAILABLE WAS HELP I COULD PAY FOR. I NEEDED IN-HOME NON-NURSING ASSISTANCE AND PERSONAL CARE. IT WAS AND STILL IS NOT AFFORDABLE.

IN 1987, MY HUSBAND WAS DIAGNOSED WITH ALZHEIMERS. THE WORSE PART IS THAT NO HELP FOLLOWS AFTER THAT DIAGNOSIS. THERE IS A GREAT LACK OF SUPPORT FROM THE MEDICAL, HEALTH, AND COMMUNITY BASED SERVICE SYSTEM. WE KNOW THAT MEDICARE DOES NOT PAY FOR EITHER MANAGEMENT OF CHRONIC ILLNESS, NOR LONG TERM CARE. I NEED BOTH OF THOSE SERVICES.

MY HUSBAND AND I HAVE BEEN SELF-SUFFICIENT AND LIVED A MODEST MIDDLE-CLASS LIFE, PLANNING FOR A COMFORTABLE RETIREMENT. HOWEVER, SINCE MY HUSBAND'S ILLNESS, OUR FUNDS ARE DWINDLING. I DO NOT HAVE RESOURCES IN MY MONTHLY BUDGET TO PAY FOR THE SERVICES I NEED NOW. I NEED RESPITE OR ADULT DAY CARE. YET WE ARE NOT ELIGIBLE FOR PUBLIC SUPPORTED SERVICES.

AS A CAREGIVER, HELP ME STAY STRONG. KEEP ME MENTALLY HEALTHY. I AM MOST HEALTHY WHEN I CAN GET OUT AND HELP OTHERS, WORKING ON SENIOR ISSUES. TO DO THAT I NEED RESPITE CARE. THE LOWEST COST CARE IN PORTLAND IS $8.50 PER HOUR. I CAN NOT AFFORD THAT SERVICE OFTEN.

I ALSO WOULD LIKE ACCESS TO COUNSELING SERVICES, FOR ME. I KNOW NOT EVERYONE NEEDS THIS SERVICE, OR SEEKS IT OUT, BUT I WOULD BE WELL SUPPORTED IF I COULD WORK WITH A COUNSELOR ON MY FRUSTRATIONS, FEARS, WHEN I AM NOT FEELING STRONG. THIS SERVICE NEEDS TO COME TO ME IN MY HOME. SUPPORT GROUPS ARE GOOD, BUT NOT CONVENIENT AT NIGHT, WITHOUT RESPITE CARE PROVIDED AT NO EXTRA COST. AND I NEED INDIVIDUALIZED ASSISTANCE.

MY BIGGEST FEARS ARE OF MY FUTURE. IF ORVILLE DOES EVENTUALLY HAVE TO MOVE INTO A LONG TERM CARE FACILITY, HOW CAN I AFFORD IT? WHAT WILL BE LEFT OF OUR RESOURCES FOR ME AND MY CARE? WHO WILL TAKE CARE OF ME? MY CHILDREN ARE NEAR BY AND PROVIDE AS MUCH AS THEY CAN, BUT I SO WORRY ABOUT THE DREAD OF MY OWN ILL HEALTH.

I DO NOT BRING ANSWERS TO YOU TODAY, I JUST BRING PROBLEMS. PLEASE HELP THE CAREGIVERS, AND MAKE THE HEALTH CARE SYSTEM MORE FLEXIBLE TO ASSURE WE GET THE REAL HELP WE NEED FOR CHRONIC CARE AND LONG TERM CARE.

Ms. UNSOELD. Thank you. Mr. Fogg.

STATEMENT OF PHIL FOGG, PRESIDENT/CEO, PRESTIGE CARE, PORTLAND, OREGON

Mr. FOGG. Thank you. I want to applaud your efforts in coming to listen to the public and hear, at this level, what's going on. I'm sure it'll result in some positive results. I had a little difficulty editing these remarks; I'll try to hurry through them and save as much time as possible.

By the middle of 1987, our long-term care delivery system was facing a crisis in Oregon. The nursing homes were forced to file a lawsuit for adequate reimbursement.

In the fall of 1987, it appeared that there may be some relief. The Judge had ruled quickly with summary judgment, that, and I quote him, "In this case I am satisfied that first of all the Defendants cut their rates solely to meet budgetary constraints. Not primarily, not generally, not in conjunction with other reasons, but primarily or solely to meet budgetary targets."

In his formal conclusion, the judge stated, "That assurances to the health care financing administration to obtain Federal approval of the 1986 Medicaid Plan, were made without facts, data or other substantial evidence to support them."

Unfortunately the State appealed this case that it had lost on summary judgment, and that appeal has not yet been heard.

In the meantime, Medicaid is paying the costs of caring for the patients at less than 10 percent of the State's nursing homes. In the midst of this depressing situation that affects care given to the elderly, Medicare came to the rescue. The catastrophic health care legislation was going to increase access to skilled Medicare coverage for a great many people.

In 1988 Medicare generally provided adequate payment, however the program was accessed by only 2 percent of those residing in nursing homes. Suddenly that picture was changing. And it could not have come at a more critical time.

The State was refusing to respond to the growing financial demands of the elderly Medicaid patient. The Federal Government was responding through this new Act.

It was an answer for everyone. Patients could get more complete coverage, providers could afford to continue providing care, the State could encourage Medicare usage, thus responding to their budgetary constrains, without cutting services to patients in nursing homes.

The interesting thing is that the new problem delivered as promised. Patient usage of Medicaid increased, providers began to get involved in the program. Over 60 nursing homes in Oregon applied for certification in 1989.

And the State changed its definition of skilled Medicaid to equate to the Medicare definition. This way skilled Medicare patients would not have to become intermediate patients and be moved to a different part of the facility when their Medicare benefits ran out.

The State was now publicly encouraging the use of Medicare, stating that Medicare would pay for 150 days and the patient's sav-

ings during that time would provide for 2 months, leaving the State to pay only 146 days before the process started again.

Today, we are weeks away from the demise of a program that became a major benefit to patients, providers and the State. Many of the 60 nursing homes who were newly certified withdrew from the certification. Other homes who had not completed their certification, simply withdrew from the process. There is every indication that the State will change its newly defined skill requirements and in general become—these patients will become intermediate patients as soon as their Medicare benefits run out. If this change does take place it will be done solely to save money and will have a negative affect on patient care.

Senator Jay Rockefeller, the chairman of the Pepper Commission, is to include in his report, due in March, how the Government will respond to several results of the catastrophic repeal, including the skilled care issue. Most observers believe that the commission will ignore skilled care altogether or only provide a band-aid response.

As I project into the future what this all means, I cannot help but reflect upon my grandmother, who started what has now become Prestige Care. She began with a mission to provide quality care for elderly incapable of caring for themselves. She taught me that there were 3 fundamentals and must always be in place to fulfill our mission. First we must offer a service that fulfills the needs and values of people seeking help. Second, we must have the professional ability to provide the desired service to our patients. And finally, we must realize a fair profit as a result for providing quality care, or we will not long survive.

Our system of nursing care for the elderly is dependent upon the Government in many situations to provide the third fundamental, adequate payment for the care provided. The State of Oregon has chosen to continue to pay legal fees rather than admit the judge was right, stating that they were driven by budgetary restraints.

The State is refusing to pay a reasonable price for care and yet to date has offered no argument accepted by the judge that they are driven by anything other than budget. The Federal Government is now facing the same dilemma with limited dollars.

With the elimination of the catastrophic health care plan, our great fear is that the Federal Government will not be willing to face the issues that affect millions of elderly people. In fact, the consistent voice out of Congress is that catastrophic health care will not be seriously revisited for 3 years.

The result is a growing crisis for elderly in our Nation. It is critical that the issues raised by catastrophic legislation be faced long before 3 years that is being predicted. If it is not addressed our system will become two tiered. We will provide one level of services for all private facilities and another for State run operated facilities. Private industry will have no choice but to leave, really forced out.

The system that provides care for welfare patients. This is a tragedy. A tragedy that is already coming to pass in States such as New York and in fact it is happening in Oregon, especially with the delivery of assisted living and foster care programs.

We must commit ourselves to working together now, not down the line a few years. If we are to develop a health care policy that is fair for our elderly citizens and to those who provide them, if the issue is ignored we will have increasingly inadequate care for the elderly and few providers that care.

How do we approach such a massive problem? I'm convinced that it must be addressed through a cooperation of three groups—government, providers, and consumers.

A few years ago, Representative Ron Wyden brought together leaders in health care to discuss the Medicare problems and how they could be addressed in a systematic fashion. I believe such meetings could be initiated by our elected officials to address the issues providing adequate care for the senior citizens and at a responsible cost.

It is unfair to conclude my remarks by describing a general approach to problems and not offer several specifics, where I am convinced the collation of government, providers and consumers could make a major impact on the health care delivery system.

Some suggestions are as follows: (1) Relating the private/public sector to create a workable long-term care insurance. We have already proven that the public and private sectors can work effectively with insurance through development of Medicare Supplemental Insurance. Currently insurance companies have developed long-term care policies that provide coverage for most types of long-term care facilities.

There are guarantee issue policies for people residing in retirement homes and assisted living facilities and desire coverage for nursing home stays. These are just a few of the growing list of creative long-term policies. Also Congress has discussed several ideas such as tax incentives, Medicaid paying for care after 2 years or being paid by insurance and private funds. There is some expiration of long-term care insurance being explored through Robert Wood Johnson Grants; however, creative discussion could and should take place on a wider basis.

Second, seniors with adequate resources need to assume more responsibility for paying for costs. The American Banking Association determined that 80 percent of the money held in savings in this country is owned by people 55 years and older.

It is imperative that people at all age levels begin to assume more responsibility. I believe that the catastrophic health care plan was on the right track when it required seniors with greater resources to assume a greater part of the financial burden. But of the repealing of the catastrophic—because of the repealing of the catastrophic Act, the validity of my premise needs examination.

Can seniors assume more financial obligation of their medical care? The answer needs to be documented and not based on opinions such as mine with limited data.

Ms. UNSOELD. I hate to hurry you along, but if you could try to—

Mr. FOGG. I'm just about finished.

Ms. UNSOELD. Okay.

Mr. FOGG. Increased taxes should be discussed. We must define what adequate care, not necessarily quality care, for those requiring State and Federal assistance. Once we have defined a health policy and determined what we will be willing to pay for, we

should pay for it. In all probability this will mean an increase in taxes. This type of serious discussion needs to take place.

If we demand quality care and refuse to pay for it, it will eliminate the providers. If we provide care for the elderly that is woefully inadequate, but is all we are willing to pay for, then we will have to change our self-image as a caring nation.

Redefine the message we send to the world as concerning human kindness. With the population of those over 65 tripling by 2030, we must in the very near future seriously address our Government's responsibility in caring for the elderly who cannot care for themselves. This means conversation concerning tax increases.

And last, we need to create a competitive environment for providers. The system allows poor care providers and providers who waste great amounts of money to provide care for State and Federal patients. Most Medicaid reimbursement formulas are weak. Most do not assure that quality care is provided. We need to create a competitive environment. We need to allow a good creative provider to afford to improve their services and provide incentives for high quality care. Consideration needs to be given for federalizing the current Medicaid system and creating a national standard reimbursement guideline and survey procedures that are consistent around the Nation.

All long-term care should be delivered at the least restrictive financially competitive environment possible. Many services provided in hospitals could be provided in long-term care settings, savings of countless dollars. For example, sub-acute, such as one care IV antibiotics, oncology, paid management, head trauma, nutritional assessment and monitoring, to name a few, could be provided in a much less costly care system.

The State of Oregon is demonstrating to the Nation that many people currently living in nursing homes can be adequately cared for and are more independent in a less restrictive environment, such as assisted living and foster care.

These are just a few of the examples in which we can approach an extremely difficult problem, provide care for the elderly population. Let us learn how to work together to provide adequate care, security for the elderly people of this land of plenty.

Ms. UNSOELD. Thank you, Mr. Fogg. Welcome to you, Kate Long, thank you for coming today.

STATEMENT OF KATE LONG, MEMBER, LONG-TERM CARE STUDY COMMITTEE, LONGVIEW, WASHINGTON

Ms. LONG. Thank you for asking me to come.

I am a member of a committee that has been studying the question of delivery of services in long-term care. And Congresswoman Unsoeld and Congressman Wyden, I'm delighted to be here and to have this opportunity to talk to you about the needs of those of us who are identified as senior citizens.

But first I must correct an erroneous impression circulated at the time of our all out campaign to revise or repeal the mis-named Catastrophic Health Bill. I want to make it clear that we did not oppose that Act because we were against paying for health care, we opposed it because only those 60 years of age and over with

medium incomes had been singled out to bear the burden of its cost. We want health care financed by citizens of all ages and all incomes. We want a bill that will eliminate a family's obligation to pay out $2,600 or more a month for the care of a family member in a nursing home. We want legislation which will keep people from pauperizing themselves in order to receive the care they need.

Long-term care is not provided, it was not provided by the Catastrophic Health Care Bill. Yet, it is the cost of long-term care that can bankrupt a family. Please think about the family. We want provisions for long-term care included in a national health bill. We must not, because of our unwillingness to face this issue, continue to contribute to the further disintegration of the American family, a structure which is already frail. We must redesign our health care system with particular attention focused on long-term care.

During the last year a long-term care committee, appointed by the Southwest Washington Agency on Aging, met regularly to study the issues involved in adding provisions for long-term care to our health care system. As a result of that study, and with the help of Kamala Bremer, its members issued a long-term care policy paper in April of this year. For your consideration at this time, I should like to present to you a summary of the findings and the recommendations of that committee.

In its opening statement the committee declared that the mission of the long-term care system should be to assure access in a balance continuum of services for persons of all ages and all incomes who have long-term functional disabilities. It further stated that the long-term care policy should encourage and provide incentive mechanisms for individuals to exercise self-determination, and for families to provide support for this disabled family members.

It also declared that a national long-term care system should be affordable to individuals and exist as a national policy within the context of other health and social needs. It would reflect the belief that the need for long-term care is a normal risk of daily life, not just of aging.

The committee recommended that the system should be open to persons of all ages who have a long-term functional disability which prevents them from performing the essential activities of daily independent living and whose needs cannot be met by informal support systems. It should include the mentally ill, the emotional disturbed and those who are neurologically impaired.

Eligibility for service should be based on individual assessment and on-going reassessments to determine any change in a person's functional abilities. Changes in services rendered should be made to reflect the results of assessment and reassessment, as well as the capability and willingness of any informal support provided to meet a client's needs.

The committee's report recommends that service plans are to be individualized and designed to meet specific needs of the individual and his family. They should enable the person to live where and how he chooses within the context of his abilities and disabilities.

A continuum of variable services should be allowed for. The solution for long-term care problems cannot be only that of placing a client in a nursing home. Other facilities such as day-care centers, family homes, boarding homes and services designed to keep a

person in his own home as long as possible should be provided. Based on the preference of a majority of consumers, community-based care should be the primary method of long-term care. Maximizing individual independent whenever possible should be a first consideration. The long-term care policy should provide incentives to care givers to continue providing care giving information and support services.

Strong mechanisms for cost containment should be built into the health care system. Financing such a system should be provided for through a vehicle, such as insurance or national coverage, for which all citizens pay equitably. Payment for coverage should be thought of as fair intergenerationally, since persons of all ages may need long-term care at some time during their lives. Low income citizens should have payments subsidized.

Broad program policies and/or the funding system, whether all public or a public/private combination, should be designed and administered at the Federal level. States should have the dominate administrative role in designing reimbursement, regulatory systems and the responsibility for local delivery. Service should be delivered at the local or the regional level. Types of managed care, including case management, should be encouraged. The States should set eligibility criteria, which should be determined at the local or regional level.

These are the recommendations of the Long-Term Care Committee of Southwest Washington. They were reached after much debate and the examination of health plan proposals from other States, as well as health care systems existing in foreign countries. They were proposed as an addition to our Medicare system, which needs revision. I hope these suggestions will be taken seriously and acted upon accordingly.

Copies of the entire policy plan are available and may be provided for you at your request. I do hope that you have comments and questions concerning the plan proposed. If you do have questions, I'll do my very best to find answers. I thank you.

Ms. UNSOELD. Our thanks to this panel. I'm going to let Ron start out this time with the questions.

Mr. WYDEN. Thank you, Madam Chair. Just a few questions if I might. Ms. Long, I'll certainly be looking at your recommendations and that's very helpful. Let me ask you two questions about your committee's work.

There are a number of private insurance policies out there today that purport to cover long-term care benefits. Did you all look at the quality of private long-term care coverage that's available today? And if you did, what is your assessment of the type and the quality of private coverage that's available right now for seniors in long-term care insurance?

Ms. LONG. I'm glad you asked me that question. In the matter of our studying the problems that we face in connection with long-term care, I can add something special because I had served on a committee of the Retired Teachers Association that has made a special study of long-term care insurance policies.

People who are my age, or who are over 65, could not possibly afford long-term care coverage in a nursing home. The cost for that would run into $2,000 and $3,000 a year in many cases. The quality

of that care needs to be carefully monitored to be certain. And in my own thinking in connection with this and with other people whom I've contacted, we are interested in staying in our homes as much as possible. Also we do not wish to become institutional cases, because as soon as that happens to us our self-motivation, our self-functioning gets cut down, and that is one of the terrible things that happens to you when you are once placed in a nursing home.

Mr. WYDEN. That's helpful, and I would be interested in seeing any material you have put together analyzing these private health insurance policies.

One other question for you, Ms. Long. There has been some discussion, you know, in the Congress and Washington among health experts about starting a voluntary Part C of Medicare. As you know Part A is the hospitals, Part B is the doctors and out-patient services. I have heard some talk about the idea of setting up a purely voluntarily Part C of Medicare that would cover long-term care, nursing home care and home health care. What, if any, thoughts would you have on something like this, and what would be your assessment as to whether something like this warrants further analysis and study?

Ms. LONG. I think that the health care that's to be delivered to those of us that might need health care supervision, I think that that should be determined on the assessment of the need of the person. You have such a variety of ailments and health conditions. Some of us don't know what's the matter with us, you see. We need to be certain to be examined so that what is the matter with us can be determined. And I think under all circumstances, the care that we need should be determined by physicians, geriatric physicians, it also should be determined by caseworkers and also by social workers, who know what is our—what do we need. And I don't feel myself that I would be competent in having to choose, that I wouldn't take Part C. I might need Part C more than I need Part A or B.

Mr. WYDEN. I know time is very short. Just one question for you, Ms. Gorshee, and thank you very much for coming and for your advocacy and please give my best to Vivian Grubb, who's a wonderful advocate and person. And I'm so glad you made this point about the respite care, because I have the view that if we don't have good respite care to care givers we're running the risk that two people—instead of one—may need nursing home care. You're going to have the person who is being cared for, but you also have the prospect that the care giver will get exhausted and will just poop out.

How many hours a year do you think would be necessary to get a good Respite care benefit? You know, we've been discussing this and examining this in the Congress. Do you have any sense of what would be a good number of hours a year in terms of outside help to spell that care giver?

Ms. GORSHEE. I need to do a quick multiplication here. I've been intrigued working with Vivian on this testimony by what she considered in a week's time. And when she was trying to figure out what she felt she could afford, she felt that she could afford about a 4-hour segment 3 times a week, but she feels that she needs to leave the home approximately 5 times a week, which would include

her grocery shopping, her—she goes to the physician at least once a week, either with her husband for monitoring of one of his illnesses. So it's interesting, I need to kind of multiple that out quickly. But that was very helpful for me, because I think they're a normal average type of case of needing Respite care.

Mr. WYDEN. You're talking probably about a couple of hundred hours a year?

Ms. GORSHEE. Possibly more than that, yes.

Mr. WYDEN. Under 300 I would think.

Ms. GORSHEE. I would say so.

Mr. WYDEN. Okay, well, that's very helpful. And Mr. Fogg, just only one point, not a question. You make this important point about not wanting to wait 3 years to start following up. Well, when Congresswoman Unsoeld said that she wanted to have this hearing to hear your views, that said we're going at it right now, right here, right away. And this notion of 3 years is just—let's just make sure the word gets out that when Congresswoman Unsoeld decided to hold this hearing, it starts right now. We appreciate all of you and it's very helpful.

Ms. UNSOELD. Thank you, Ron. Kate, a toughie I want to throw at you. What are we going to do first? Should Congress act separately to expand the coverage for long-term care, or do we try to do it in a more comprehensive national health insurance plan?

Ms. LONG. I think that's for you to decide, because of the fact that you know the circumstances at the present time and you all, I think we need to do what we can get. I do think we have to think we must plan in the future for a national health care system that takes care of all problems, of all people, according to their need and according to their income probably, too. But I can't say—you know, I depend on you to know what you can get. You've always been truthful. And sometimes I haven't liked it. But on the other hand I depend on you to know what we can get. If you say we should piece by piece, all right. Of course I'd love to have a completely revised system. I'm not sure we're ready for that yet, so let's do it the way we can get what part of what we need and then it'll have to be worked on over a period of years. Is that all right for me to say?

Ms. UNSOELD. Yes, I appreciate your frankness, because obviously it's something that we who are the elected officials and you who on a day-to-day basis are dealing with the problem, we're going to have to work very closely together, and I don't know yet which is politically the more realistic, to be able to work for the whole thing now or to try to get a piece, but I think that long-term health care, home health care has certainly got to be at the top of—

Ms. LONG. It'll have to be.

Ms. UNSOELD. —the priority list.

Ms. LONG. I think so.

Ms. UNSOELD. I wondered whether your group had examined the availability of private long-term coverage and whether you felt it was a realistic option for most seniors?

Ms. LONG. I don't—if you mean that each—the seniors will pay for it themselves, they can't.

Ms. UNSOELD. Okay.

Ms. LONG. They don't have the money to pay for it.

Ms. UNSOELD. So, even as an insurance cost they cannot afford it all by themselves?

Ms. LONG. Not all by themselves. We need to work it together and I think it needs to be all of our citizens involved, all of our family people involved.

Ms. UNSOELD. How are we going to figure out what seniors can afford to pay for this protection and are willing to pay? Should we be looking at it straight across the board for all members of society, and/or should we be thinking in terms of a little more payment by those who are most directly receiving benefits?

Ms. LONG. I would think those that have—it's like with your income tax, if you have more income, all right. Then you pay more into it. But I don't think anybody should be left out. I don't think you should have a cut-off point as you did in the catastrophic health bill. If you have below this you pay, but if you're above, you go in free, no, no.

Ms. UNSOELD. Okay. Well, I very much appreciate the panel and we will continue to learn together and to work together.

Ms. LONG. Well, thank you so much.

Ms. UNSOELD. Thank you.

Ms. LONG. You're a nice person.

Ms. UNSOELD. Thank you, again.

The next panel, please. Ms. Peterson and Mr. Erwin—yes, there they are. I appreciate that you all did a short turn-around to be able to accommodate us and to bring your expertise to this hearing. Ms. Petersen.

STATEMENT OF PATRICIA PETERSEN, DEPUTY INSURANCE COMMISSIONER, WASHINGTON INSURANCE COMMISSION, WASHINGTON

Ms. PETERSEN. Thank you. Congresswoman Unsoeld, I remember being at the Friendship Hall at the YWCA when you were first running for the state legislature. Our region is so proud to have you.

Ms. UNSOELD. Thank you.

Ms. PETERSEN. Representative Unsoeld and Representative Wyden, on behalf of Insurance Commissioner Dick Marquardt and Washington State, thank you very much for inviting me to testify before you today.

I am Patricia Petersen. I am a Deputy Insurance Commissioner for the State of Washington. I have been in that position for 5 years, and I am an attorney; I left a private law firm in Seattle after several years to take this position.

My responsibilities include being in charge of RPN sales for health insurance to the elderly. I also—of course, while Federal law is a source of standards for private Medigap insurance policies which are intended to supplement Medicare, the State of Washington within those parameters has of course adopted its own statutes and regulations to further effectuate those goals.

The States also are in practice solely responsible for reviewing Medicare supplement policies, long-term care policies, and approving them or disapproving them. Also for enforcement of marketing and sales tactics, enforcement of the loss ratio regulation that we

have, which again is under the parameter of the Federal law. And for virtually all aspects of Medicare supplement and long-term care private health insurance. In that respect we're a very busy office. Each State, of course, is in charge of their own policies which apply to their own residents.

I am a legal advisor, too, to our division that does review the long-term care and Medicare supplement insurance markets, as well as other health insurance. So, I'm intimately involved with the various provisions of the policies and what there is and what there isn't.

I would like to say, too, your hearing as hands across the river, let me say that marketing tactics are also across the river. They go back and forth over boundaries. It was said in 1987, when I testified before this Subcommittee before, that enforcement by States is piecemeal in this area, and indeed it is that way. We really need to have more uniformity in our State laws, but I will tell you in the next few minutes about Washington State's experience in this area.

I'd like to recommend, though, a Consumer Reports article to you, as well as to your constituents. I was a contributing author to this, and it's in the June magazine. It's about a 20-page kind of a short primer on Medigap insurance, what to look out for in the marketing area and technically what to look for in terms of coverage of policies. And I think that in the time it takes to read it, it would be of good educational value to a lot of your constituents.

You have requested from me to testify solely about the marketing sales of Medigap insurance and also long-term care insurance today, and so I'll try to give you a brief sketch of the kinds of problems that Washington State is having.

I would also like to refer you to my 1987 testimony which I did present in Washington in June of 1987, and that is a more detailed statement about marketing and sales. They, in most respects, have changed very little.

In the first 10 months of 1989, the Washington Insurance Commission has taken 35 formal disciplinary actions against Medigap companies or agents for serious abuses in the sale of Medicare supplemental insurance, and it has also taken 7 formal disciplinary actions in the long-term care insurance sales area for a variety of reasons.

There are about 6 major types of senior health insurance marketing fraud that occur in Washington State. There is always your receipt of premiums by a Medicare supplement agent and conversion of those funds to his own use, which is of course, embezzlement. We have that not uncommonly in our State. I have files here I can describe in detail, but that probably wouldn't be of that much interest to you.

Another tactic is "clean sheeting." State law prohibits an agent from filling out the medical information portion of the application for any form of senior health insurance. Agents somewhat commonly fill this out themselves and they "clean sheet" the application, which means that they intentionally leave the adverse, the bad health information out of the application. Now this results in the issuance of the application to the senior and collection of the commission for the agent, but at the time that the senior has a medical claim that claim is often denied, of course, because the

company by that time has found out that there has been a pre-existing health problem and they often assert to our consumer complaints analyst that they would not have issued the policy in the first place had they known of the ill health. Well, it's not the fault of the senior that it wasn't in there, but the agent has caused problems, and we try to get those straightened out. But of course only a small portion come to our office for assistance.

Duplicative policies. We do have no definition of what a duplicative policy is. I know the Federal Government has tried to make a definition of that. That is unclear at this time, as far as the State enforcement activities are concerned. So we do have sales of 2 or 3 policies, not uncommonly we'll find a consumer with that kind of coverage. There is no reason, in our opinion, for having more than one good Medicare supplement policy.

The fourth common activity is Medigap agents will "roll" consumers from one policy to another year after year. The reason for that is the first year they'll get 100 percent, or 110 percent even, commission on a first year sale of a Medigap policy; following years they will receive about 45 percent or less commission, so they will actually make quite a bit more income on a first-year sale. The adverse consequence to a senior consumer, of course, is that the pre-existing condition limitation which is typically 6 months will run again, or the consumer will actually get turned down for the second policy.

Our fifth major area is "lead cards." And I went into this in 1987 in detail, and this Consumer Reports article has an entire page on what a lead card operation is. I think most of your constituents have seen lead cards before. They are situations like this, "Christian Associations of Retired Persons"; they're selling—they don't call themselves an insurance agent or insurance plan, they offer you some minimal other benefits like savings on optical care, major hotel discounts, a 30 percent discount on Bibles—and actually, when you call in and you want to know about a discount on Bibles or health care information in general, you call in the number that is actually an insurance agency. And all they do is sell insurance. I issued a stop order on them in July of this year and hopefully that will be the end of them. However, we have a lot of other kinds of enticing mailings in Washington, and I know they go over the border in Oregon, and most of these lead companies are nationwide. They're non-insurance companies.

Normally agents or even non-agents using other names like "Christian Association of Retired Persons" to get senior leads that they then sell to insurance agencies or companies for a profit to themselves. They sell the cards that are returned, "Yes, I'm interested in Bibles or health information"; they'll sell them to an insurance company for $8 to $24 a card. They make literally millions. A large company in 1986 sent out 6 million of these cards in one year. And I did stop them, but I think that they've simply just changed their name.

We have old ones. I brought these up last time. These are the old ones, however, and we stopped these, but these are the new ones. These talk about, now it's probably the same company. I have proof that some of them are the same company, this one even had the audacity to use its same name, even though there was a cease and

desist order issued against it. It's one of the largest in the country, it's out of Texas.

The new ones kind of a set ceiling on Medicare benefits. We've got some about the catastrophic care Act already. "Congress sets regulations on Medicare and catastrophic protection payments." They simply just sell these to insurance agents. They, of course, are of great concern of seniors, because they tell you things like "if you only have this card, you cannot afford to get sick," enticing, scary, frightening things and it's simply to sell insurance. So we worked long and hard to try to get these either into conformity with State statute or not to be mailed in Washington. Our battle, to be quite truthful, it's very uphill.

We have our own flock of Washington companies, American Health Care Information Group is one that we're working on now trying to identify just what they think their function is. Because again, their phone number is an insurance agency.

Another—the final major area of Medigap and long-term care now, fraud in the sales area is television advertisements. Washington stopped about 8 or 9 television advertisements in the last couple of years. Recently we've worked on the Senior Life Insurance advertisements, the Ed McMahon advertisements and so on. But with regard to the Medicare supplement advertisements, those were somewhat cleaned up in Washington as of the end of 1987. But this year we came across Colonial Penn Franklin Insurance Company making the same misleading and deceptive statements that they made on television in written form. So I issued a cease and desist order against them and fined them $10,000.

But it's a cat-and-mouse game to some extent. It's a very difficult area that is not—Washington may be held up as somewhat of an example nationally, but really we're not, we're real far from perfect and our battle is strictly uphill.

Generally other kinds of statements, as Congressman Unsoeld remarked, 50 percent of actual charges are covered by Medicare supplement policy and Medicare. That is not brought up in a lot of the advertisements. They say that you have a $200 deductible. They don't let you know that there is a doctor's gap in there; most often, if the doctor does not accept assignment, they don't bother to mention that, some of the companies.

And other kinds of issues arise. Medicare allowable, that term of art within the Federal law, is not defined in policies. That is something that is often misleading to consumers, and we've tried to work on that. But again, the remarks come back; well, the Federal law, that's what they call it so how can you, the States, tell us that we have to further define it or call it if that's what's in the Federal law. So there are a number of other kinds of abuses that are of a variety, of various kinds of problems.

At the time that Congressman Dingell and Florio held hearings in the above issues this past spring, and Congressman Dingell ordered the GAO to conduct a study of this marketing area, the National Association of Insurance Commissioners initiated a task force to draft a model consumer protection regulation. And such national models are subject to State's adoption as State law at the State's option.

That was in response, again, to these marketing concerns. The draft set forth substantial protections against the above situations. For example, they made commissions level to prevent this rolling tactic. They made specific and strict sanctions for publication of misleading and deceptive advertising. And they gave States jurisdiction over leads companies, which the majority of States do not believe that these types of lead companies are within the State jurisdiction. However, I am now informed that the NAIC has dropped that project from consideration and the draft has been withdrawn from consideration as a national model.

Another area that I have been asked to talk about just real briefly is our loss ratios. Loss ratios of course are the regulators method, the State—are set forth in Federal law and within that under those auspices, the State's impose their own loss ratio regulations. They are the regulators method of keeping insurance rates reasonable in relation to the benefits that are provided.

At this time Washington State does believe that a substantial number of Medicare supplement companies operating in our State have loss ratios that do not meet this figure. That means that they are making more income than they are legally required to, legally allowed to make.

As I talked about in my 1987 testimony, Washington has been one of the more active States in attempting to monitor loss ratios. However, this has been a very difficult task. We have difficulties even in obtaining documentation from the companies that will allow our actuaries to even assess if the loss ratio stated is accurate or not.

We have been operating under the NAIC model loss ratio regulation, which has been—which is in place in the great majority of States. We have found, however, that this model is too weak for effective enforcement, so we have written our own loss ratio model for use in Washington, which makes the percentage that has to be paid out in claims higher, 5 percent at least higher than the national model, and it gives us more teeth in order to try to procure the documentation that we need to see what those profits of the Medigap companies are.

We've made the mandatory loss ratio percentages rather than just target those which are set forth in Federal law. And we hope that with the use of our new regulation, which comes into effect in January, that we will be able to monitor loss ratios in a more effective manner.

Finally, you had asked to hear a little bit about our SHIBA program. This is the Washington Senior Health Insurance Benefits Advisors Program. This has been in our State for 13 years. And basically it's a group of about 400 senior citizen volunteers which advise other seniors regarding enrollment and rights under Medicare and the choice of Medigap policies and long-term care policies; assistance in filing claims and obtaining benefits under Medicare and Medigap insurance, and a problem resolution or a referral to the insurance commissioner's office.

This group has no regulatory authority or legal entitlement to enforce sections of the Medicare supplement rules and regulations. However, they're of great benefit to our office in terms of helping

seniors prevent problems in the first place or working them out in an informal basis with companies.

They reach and help 55,000 of Washington's seniors annually, with 23,000 volunteer hours. We have 4 employees in our office which coordinate this program and teach seniors through required training courses about the subject so that they can help others. Our offices are 100 offices throughout the State of Washington. They're all in donated space, usually with retired senior volunteer programs and other kinds of civic organizations. Our budget for this program is $250,000 per year. So we feel that it's of a great value for Washington's senior citizens.

We have had requests from about 30 States requiring information about the SHIBA program and we do know of a small number of States who have put these into effect. We have a brochure that we send out, we update and send out regularly, the SHIBA manual. Basically it talks about SHIBA, I think that's exhibited to my testimony. And we also have information about purchasing various kinds of senior health insurance.

In summary, over the years we have seen that the Medigap insurance industry either cannot or does not choose to correct a good number of its abuses. Elderly consumers, which are the most vulnerable members of our society, are the ones who are affected by this industry. And while States currently regulate this area with varying degrees of enthusiasm, this is a market which cries for increased attention. All States must regulate this industry effectively, and in many areas our methods and means should be strict and should be uniform throughout the States.

While the above is only a brief sketch of the type of activities with which the State is concerned, it does exemplify a continuing national problem. Obviously when you have a lot of confusion there are going to be companies and individuals that are going to take advantage of the individuals in the particular market. It is very confusing. I can't even understand some of the policies, it's very confusing. And let there be no mistake about that.

A couple of notes I made during the other testimony. I wanted to just mention, I believe also that the Federal law still does not allow—while you did keep in the requirement for Medicare supplement advertisements to be submitted to the State's there is no obligation for the States to do anything about it. There is no organized system of review. I know States that don't do anything about it, there are some States that try but they have no system. There's a variety of what happens to it. So I appreciate it being left in, that's a sign that you're concerned about it. It's, really again, it's left completely up to the States what we choose to do with it.

Also, I don't think that there are any Federal provisions for reviewing the Federal standards for Medigap policies. I know they weren't to the date until—when I looked. I think that that's a problem because you know, you're talking about drug coverages and such and that is something that over time with the rising health costs and the various kinds of medical advancements, I think that a review of those requirements needs to be had.

Mammography was mentioned many times. I believe the State of Washington, again, was held up. We have a mandated benefit effective January 1st for group policies for mammograms. I believe that

that does not apply to Medicare supplement policies. I will check on that and let you know, but I believe it doesn't. I'm pretty sure it doesn't apply to them, which is too bad now, of course, that it's not in Medicare.

Drug coverages—obviously it's a great problem for a lot of our senior consumer complainants. Mrs. Oberheide is indeed very fortunate. She's a rare person to have that kind of coverage, the coverage that she has under her particular policy. That is not at all common to have that kind of coverage. It is not common at all to have coverage up to actual charges. Normally of course it is only up to the approximately 50 percent coverage there.

Is the long-term care option realistic for seniors? For some seniors, of course these policies are underwritten for some seniors they would not qualify now, for others a pre-existing condition limitation in the policy would be a real hardship for some and then there would be those that would qualify. But basically, from an insurance company's standpoint, there would be a good number of seniors that couldn't even purchase it at this point in time privately.

Thank you very much. I'd like to fill you in on anything I can and also keep in touch with you in the future.

[Additional material submitted for the record by Ms. Petersen follows:]

RICHARD G. (DICK) MARQUARDT
INSURANCE COMMISSIONER

DAVID H. RODGERS
CHIEF DEPUTY

STATE OF WASHINGTON

REPLY TO
OLYMPIA OFFICE
INSURANCE BUILDING
OLYMPIA, WASHINGTON 98504-0321
753-7300, AREA CODE 206

OFFICE OF
INSURANCE COMMISSIONER

In the Matter of	)	No. D 89 - 8
	)	
NATIONAL FEDERATION OF RETIRED PERSONS, a not for profit Texas corporation,	)	Findings of Fact, Conclusions of Law and Order on Hearing
	)	
an Unlicensed, Aggrieved Entity.	)	

TO: National Federation of Retired Persons
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San Antonio, Texas 78217

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Insurance Commissioner Richard G. Marquardt

Deputy Insurance Commissioner Robert E. Johnson

Pursuant to Ch. 34.04 RCW and Ch. 48.04 RCW, and to the Notice of Hearing issued in this matter on January 23, 1989, the above-entitled matter came on for hearing on Thursday, February 16, 1989, at 9:30 a.m., at the Office of the Insurance Commissioner, Insurance Building, Olympia, Washington. All persons to be affected by the matter were given the right to be present during the giving of all testimony, and had reasonable opportunity to inspect all documentary evidence. The Insurance Commissioner was represented by Robert V. Jensen, Assistant Attorney General. The National Federation of Retired Persons was represented by Ralph R. Smith, Attorney at Law. Witnesses giving testimony at the hearing included Elmer B. Gibson and Patricia D. Petersen.

NATURE OF PROCEEDING

The purpose of the hearing was to determine if the Insurance Commissioner has jurisdiction over the National Federation of Retired Persons (hereafter NFRP) and its proposed activities, and, if so, the extent of such jurisdiction. The NFRP had previously filed a suit for declaratory relief in Thurston County, Cause No. 88-2-01933-6, which

dealt with these same issues. After that suit was dismissed on January 9, 1989 for failure to exhaust administrative remedies, NFRP filed a request for an administrative hearing on January 13, 1989.

FINDINGS OF FACT

Having considered the evidence and argument presented at the hearing, as the Deputy Insurance Commissioner designated to hear and determine this matter, I find as follows:

1. This hearing was duly and properly convened and all substantive and procedural requirements under the laws of the State of Washington have been satisfied.

2. NFRP was incorporated as a non-profit corporation in the State of Texas in 1979. Prior to that for several years, NFRP acted as an unincorporated association. It is not a tax-exempt organization under the Internal Revenue Code, nor has it applied for such status. (Testimony of Gibson)

3. NFRP describes itself as a "philanthropic, non-profit association to benefit retirees and matured persons." It states that it offers benefits to its members in several areas, including: a Consumer Aid Program, a Health Education Program, a Purchase Privilege Program, and a Travel Service. (Ex. 10, p.4) No testimony was presented at the hearing concerning the Purchase Privilege Program or the Travel Service.

4. Officers of NFRP include Ed Cochran, President; Deborah Cochran, Secretary/Treasurer; and Patricia Earl, Vice-President. Elmer B. Gibson, who testified at the hearing, is a member of the Board of Directors and the acting Executive Director of NFRP. Elmer B. Gibson and Deborah Cochran are married to each other; Deborah Cochran is the daughter of Ed Cochran. Ed Cochran was one of the incorporators and initial directors of NFRP.

5. As examples of materials printed by NFRP for distribution to members and non-members, four brief pamphlets were submitted at the hearing. (Ex. 4) These pamphlets all note that they are reprinted by the NFRP from a brochure of the U.S. Department of Health and Human Services. The "Guide to Health Insurance for People with Medicare," which NFRP also distributes, is similarly reprinted from a publication of the Department of Health, Education and Welfare. (Ex. 10) The "Guide" is sent by the NFRP to persons who respond positively to the materials contained in Exhibit 10. Mailing of these reprinted pamphlets appears to constitute the Health Education Program of NFRP.

6. As part of its Consumer Aid Program, NFRP regularly sends materials concerning Medicare Supplement insurance to members and non-members both. NFRP uses mailing lists purchased from commercial providers. The materials say that NFRP has reviewed several Medical Supplement insurance programs. They note that the policies are sold to NFRP members and non-members alike. They give opinions on the plans

such as "These programs offer outstanding benefits and have reasonable rates." They include statements such as "If you act now there will be no health questions and will cover pre-existing conditions (sic)" and "At this time, there are programs available that guarantee your acceptance and there are no health questions asked" (emphasis in original) (Ex. 10)

7. The mailings described in Finding #6 above also include a postage paid business reply card, which the recipients are instructed to complete and mail to NFRP. The two forms submitted at the hearing are slightly different, but both call for the ages of the recipients, their phone number, and the county of their residence. Neither of the forms states that if a person completes and returns it he will be contacted by an insurance agent. One says, "For full information without any obligation complete card and mail today!" The other has a box to check, alongside the statement: "YES Please see that I receive further information." (emphasis in original)

8. Of the two form letters which apparently accompany the business reply cards described in paragraph 7, one does not mention that an agent will contact the person. It simply says, "If you would like further information on the programs that we have reviewed, as well as your free copy of the 'Guide to Health Insurance for People with Medicare,' let us hear from you." The other letter does inform the recipient that an agent will contact them, saying: "P.S. IMPORTANT: If you have shown an interest in the Medicare Supplements we have reviewed (by completing and mailing the card), a licensed agent will call to answer any questions you may have about Medicare Supplements available to you." (emphases in originals)

9. After NFRP receives the completed business reply cards from those persons showing an interest in Medicare Supplement insurance, these positive responses or "lead cards" are offered for sale to insurance companies and individual insurance agents. Most of the cards are sold for a flat price in the range of $12 to $20 per card. The NFRP's compensation is not contingent upon the purchasing agent making a successful sale to the person completing the "lead card." Most of the cards are sold to individual agents doing business in the geographical area covered by the mailing, rather than to insurance companies. NFRP obtains the names of the agents to whom it offers the positive reply cards from lists which it purchases, usually from state insurance departments. (Testimony of Gibson)

10. NFRP does not limit sales of the "lead cards" to those companies whose policies have been "reviewed" by the NFRP as stated in its mailings and generally described in those mailings. Similarly, it does not limit sales of the "lead cards" to only those agents who actually are appointed to represent at least one of the insurance companies whose products have been "reviewed" by the NFRP. The NFRP makes no attempt to ascertain the companies by which an agent is appointed before it sells him or her the "lead cards." Thus, if a person does complete and return the "lead card" to the NFRP, there is no guarantee that they will be contacted by a company whose Medicare Supplement

product has been "reviewed" by the NFRP, or by an agent appointed by such a company. In fact, the NFRP makes no effort at all to ensure that this will happen. (Testimony of Gibson)

11. The $12 to $20 fee for each "lead card" paid by the agents and companies "might well possibly be" the biggest source of income to the NFRP, according to the testimony of its Executive Director. While there is a $10 membership fee to belong to the NFRP, the Executive Director of the NFRP could not give a percentage breakdown for the NFRP's income among such membership fees, donations received by it, and income derived from "lead cards." (Testimony of Gibson)

12. The NFRP's Executive Director could not remember how many people attended the NFRP annual meeting in any particular year. Although he was sure that there must be a record of such attendance "somewhere," the NFRP does not maintain any records of such attendance. According to the Executive Director, it is a "moot question" whether a person is a member of the NFRP or not, since the organization will do the same things for non-members as it does for members. (Testimony of Gibson)

13. In response to a subpoena duces tecum from the Attorney General, the NFRP submitted unsigned copies of its federal income tax returns from 1980 through 1987, inclusive. (Ex. 3) The Executive Director of the NFRP indicated that these copies were identical to, or at least contained the same information as, the returns actually filed with the IRS. The copies show the following, with negative numbers in parentheses:

Year	Gross Receipts	Printing Costs	Taxable Income
1987	$ 587,361.17	548,659.88	15,592.83
1986	$ 92,789.20	129,236.17	(154,500.14)
1985	$ 237,630.44	98,796.30	(101,727.55)
1984	$ 406,433.64	10,991.57	4,777.33
1983	$ 533,145.34	386,081.71	13,079.88
1982	$ 178,973.79	161,059.46	(6,617.83)
1981	$ 45,497.00 *	31,768.00	(319.00)
1980	$ 525.00 *	-0-	(361.43)

* In 1981 and 1980, the line for "gross receipts" is left blank. The amounts listed are from line 10, "other income," and are described on the returns as "membership fees."

14. The table in paragraph 13 above indicates that the bulk of the NFRP's gross income has gone for costs associated with the printing and

mailing of the materials it sends to persons, members and non-members alike. The returns are somewhat inconsistent from year to year in the manner in which such costs are broken out. For example, in 1985, $98,796.30 is listed as the expense for "printing," with another $105,917.03 listed for "computer services," which appear to be related to the NFRP's mailing program. In 1984, only $10,991.57 is listed as "printing," but another $138,490.15 is listed as "postage and meter rental" and $53,336.13 for "computer services." In 1983, "printing and mailing" are listed as $386,081.71, while there is no separate listing for postage or computer expense. However the expenses are precisely broken out, the figures for "taxable income" in the final column show that for the years 1980-1987, there was little money left over from gross income after expenses had been paid. The great majority of the expenses listed for those years relate to the mailings of the NFRP.

15. The copies of the tax returns of the NFRP also indicate the following:

Year	Compensation to Officers	Salaries and wages
1987	-0-	-0-
1986	-0-	-0-
1985	-0-	$400.00
1984	$7,577.24	$35,965.75
1983	-0-	$28,635.46
1982	-0-	$ 2,799.51
1981	-0-	-0-
1980	-0-	-0-

16. The NFRP's Executive Director indicated that the reason the figure for "salaries and wages" changed dramatically after 1984 was that the NFRP had a staff printer prior to that time; subsequently, the NFRP has contracted out the printing. (Testimony of Gibson)

17. Mr. Gibson, the NFRP's Executive Director, testified that for the last several years the NFRP had contracted out its printing work to a company called "Mail Surveys," a Texas corporation. He indicated that this had been done after an open competitive bidding process in which "Mail Surveys" was the low bidder. He also indicated that he did not know the names or addresses of the directors of "Mail Surveys," but that he could get them. (Testimony of Gibson)

18. Subsequent to the hearing, on March 8, 1989 the hearing officer received an affidavit of Robert V. Jensen, the Assistant Attorney General representing the Insurance Commissioner in this matter. The

affidavit concerned the corporate records of Mailing Surveys, Inc., a Texas corporation. Attached to the affidavit were certified copies of the Articles of Incorporation, a Change of Registered Agent and/or Office, and a list of officers and directors of Mailing Surveys, Inc., from the Office of the Secretary of State of Texas. The cover letter from Mr. Jensen indicated that a copy of this affidavit and attachment were sent to Ralph R. Smith, attorney for the NFRP in this matter. No materials or objections in response to this affidavit, or to the request that it be made part of the record of the hearing, were ever received from the NFRP or its attorney. Accordingly, the affidavit and its attachments are admitted into the record as Exhibit 16.

19. The corporate records described in paragraph 18 above indicate that the original incorporator of Mailing Surveys, Inc. was John C. Stahl, 111 Towne Vue Drive, San Antonio, Texas. The three original directors were Mr. Stahl; Deborah C. Gibson, 10523 Asteroid, San Antonio, Texas; and Edwin E. Cochran, 11947 Alamo Blanco, San Antonio. Texas. The registered agent of the company was Deborah Gibson, first at the 10523 Asteroid, San Antonio address, and then as of March 28, 1988, at 10914 Wye Drive, San Antonio. Deborah Gibson is presently a director and president/treasurer of Mailing Surveys, Inc.

20. John C. Stahl, 111 Towne Vue Drive, San Antonio, Texas, was also one of the original incorporators and directors of the NFRP (exhibit 12). Deborah C. Gibson is the wife of Elmer Gibson, the Executive Director of the NFRP, who gave his home address as 10523 Asteroid, San Antonio, Texas. Deborah C. Gibson is also the daughter of Edwin E. Cochran. Edwin E. Cochran, 11947 Alamo Blanco Drive, was also an original incorporator and director of the NFRP, and is now its president.

21. As a witness, Mr. Elmer Gibson sometimes spoke in such a way that it was difficult for the hearing officer to understand exactly what he was saying. He was frequently somewhat imprecise in his responses to questions. In part because of that, and in part because of the overwhelming identity between the directors and incorporators of the NFRP and Mailing Surveys, Inc., the hearing officer finds that Mailing Surveys, Inc. of San Antonio, Texas is the company which performs the mailing services for the NFRP. The hearing officer also finds that Elmer Gibson's testimony that he did not know the names and addresses of the directors of Mailing Surveys, Inc. is not credible.

22. Although the records from the Secretary of State do not indicate ownership of the stock of Mailing Surveys, Inc., it appears to be highly likely that one or more of John C. Stahl, Deborah Gibson, and Edwin E. Cochran own stock in Mailing Surveys, Inc. Because of that, and because of the findings made in paragraphs 19 through 21, the testimony of Elmer Gibson that Mailing Surveys, Inc. was awarded the NFRP printing contract after open, competitive bidding is not credible.

23. Based on findings 15 through 22, it would appear, and the hearing officer so finds, that while the directors and officers of the NFRP do not take any salary directly from the NFRP, one or more of such directors and officers do benefit financially from the NFRP's operations. This is accomplished through the mechanism of the NFRP's contract for mailing services with Mailing Surveys, Inc.

CONCLUSIONS OF LAW

1. The NFRP materials concerning Medicare Supplement insurance and eliciting an indication of further interest, as exemplified by the materials in Exhibit 10, are subject to Ch. 284-50 WAC, the Washington Disability Insurance Regulations.

2. Ch. 284-50 WAC is applicable to these materials because they are sent to persons by the NFRP "...directly or indirectly...on behalf of an insurer, agent, broker, or solicitor," per WAC 284-50-020. This is so even though the NFRP may not have an agreement with a particular insurer or agent before it sends out a particular mailing. The NFRP engages in a clear, repeated course of conduct in the solicitation of interest in Medicare Supplement insurance from potential purchasers of insurance, and the sale to insurers and agents of "lead cards" evidencing that interest.

3. WAC 284-50-030 (7) and (8) provide as follows:

> (7) 'Institutional advertisement' for the purpose of these rules shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.
>
> (8) 'Invitation to inquire' for the purpose of these rules shall mean an advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the loss for which the benefit is payable,...

4. The materials sent by NFRP as exemplified in Exhibit 10 are either "institutional advertisements" and/or "invitations to inquire" as those terms are described in WAC 284-50-030(7) and (8). As such, they are subject generally to Ch. 284-50 WAC.

5. The materials in Exhibit 10 violate WAC 284-50-100, which provides in pertinent part:

> (1) Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement is subject to all the provisions of these rules.
>
> (2) If the person making a testimonial, an endorsement, or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement, or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: 'Paid endorsement.'...

> (3) An advertisement shall not state or imply that any insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organization, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed....

The materials in Exhibit 10 violate these sections in that they do not disclose the fact that the NFRP receives compensation from insurers and/or agents for selling the "lead cards" which are returned to it in response to these materials. They do not include the phrase "Paid endorsement" or its equivalent. Rather, the materials depict the NFRP as a non-profit service organization benefiting mature persons, and are silent about the compensation paid to the NFRP, as well as the money paid by the NFRP to Mailing Surveys, Inc. Further, the testimonials are not "genuine" in light of the testimony concerning the NFRP's annual meetings and the proceedings thereat, as well as testimony concerning the NFRP generally. Finally, NFRP makes no effort to ensure that the individual will be contacted by an insurer or agent of an insurer which actually issues one of the products endorsed by the Exhibit 10 materials.

6. WAC 284-50-150 provides in part as follows:

> (1) The full legal name (and, where required by RCW 48.30.050, the home office) of the actual insurer shall be shown in each advertisement...

The materials in Exhibit 10 do not mention the name of any insurer. Further, no attempt is made to ensure that the person who sends in a reply card will be contacted by or on behalf of an insurer whose policy is described in the materials as one of those "reviewed" by NFRP. Accordingly, the materials in Exhibit 10 violate WAC 284-50-150.

7. WAC 284-50-060 provides in part as follows:

> (1) No advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable....
>
> (2) No advertisement shall contain or use words or phrases such as, 'all'; 'full'; 'complete'; 'comprehensive'; 'unlimited'; 'up to'; 'as high as'; 'this policy will help fill some of the gaps that Medicare and your present insurance leave out'; 'this policy will help to replace your income' (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.
>
> ...

The materials in Exhibit 10 include phrases such as the following:

- "There are several plans that we feel have outstanding benefits with reasonable rates."
- "some programs that pay **100% of covered hospital charges**"
- "All of these programs cover **pre-existing conditions.**"
- "programs available that **guarantee your acceptance** and there are **no health questions asked.**"
- "**If you act now there will be no health questions and will cover** (sic) **pre-existing conditions.** (emphases in original)

These statements are made without discrimination; apparently, all of them apply to all the policies "reviewed" by the NFRP. Yet, no individual policy or individual company is named. Further, no attempt is made by the NFRP to ensure that a person who sends in the "lead card" will be contacted by or on behalf of any company that actually sells one of the products "reviewed" by the NFRP. In totality, the advertisements comprising Exhibit 10 have the capacity, tendency, or effect of misleading or deceiving prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. Further, the advertisements appear to exaggerate benefits beyond the terms of the policy or policies being advertised. Accordingly, the materials in Exhibit 10 violate WAC 284-50-060(1) and (2).

8. In adopting the statutes which comprise the insurance code, Title 48 RCW, the legislature intended to completely fill the field of insurance regulation. RCW 48.01.020 provides as follows:

> **Scope of code.** All insurance and insurance transactions in this state, or affecting subjects located wholly or in part or to be performed within this state, and all persons having to do therewith are governed by this code. (emphasis added)

9. The legislature has also recognized that insurance is a business specially imbued with the public interest. RCW 48.01.030 provides:

> **Public interest.** The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, and their representatives rests the duty of preserving inviolate the integrity of insurance. (emphasis added)

10. The phrase "insurance transaction" used in RCW 48.01.020 is defined in RCW 48.01.060:

> **'Insurance transaction' defined.** 'Insurance transaction' includes any:
> (1) Solicitation.
> (2) Negotiations preliminary to execution.
> (3) Execution of an insurance contract.
> (4) Transaction of matters subsequent to execution of the contract and arising out of it.
> (5) Insuring. (emphasis added)

11. The materials contained in Exhibit 10, and the way they are used by the NFRP, constitute a "solicitation" as that phrase is used in RCW 48.01.060.

12. RCW 48.05.030 provides in pertinent part:

> Certificate of authority required. (1) No person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority issued to it by the commissioner and then in force; except, as to such transactions as are expressly otherwise provided for in this code. (emphasis added)

13. In addition to insurers themselves, only three entities are "expressly otherwise" permitted to engage in the "insurance transaction" of soliciting insurance.

RCW 48.17.010 provides so:

> 'Agent' defined. 'Agent' means any person appointed by an insurer to solicit applications for insurance on its behalf. If authorized so to do, an agent may effectuate insurance contracts. An agent may collect premiums on insurances so applied for or so effectuated. (emphasis added)

RCW 48.17.020 provides so:

> 'Broker' defined. 'Broker' means any person who, on behalf of the insured, for compensation as an independent contractor, for commission, or fee, and not being an agent of the insurer, solicits, negotiates, or procures insurance or reinsurance or the renewal or continuance thereof, or in any manner aids therein, for insureds or prospective insureds other than himself. (emphasis added)

RCW 48.17.030 provides so:

> 'Solicitor' defined. 'Solicitor' means an individual authorized by an agent or broker to solicit applications for insurance as a representative of such agent or broker and to collect premiums in connection therewith...(emphases added)

14. It is illegal to act as an agent, broker, or solicitor without a license. RCW 48.17.060 provides in pertinent part:

> (1) No person shall in this state act as or hold himself out to be an agent, broker, solicitor, or adjuster unless than licensed therefor by this state.
> ...

15. The result of RCW 48.01.020; 01.060; .05.030; .17.010; .17.020; .17.030; and .17.060, taken together is this: in order to engage in

the insurance transaction designated a "solicitation," one must be either an authorized insurer or a licensed agent, broker, or solicitor. No one except those four entities may lawfully solicit insurance in Washington.

16. The NFRP does not readily fit into any of the four categories listed above. However, that is not the point. It is not up to the Insurance Commissioner to torture the statutory definitions of these four entities to see which one can best be made to cover NFRP. Rather, it is incumbent upon the NFRP - if it wishes to engage in the solicitation of insurance - to organize itself in such a fashion as to qualify for legal recognition as one of these entities, and the authorization to act as such. Until it does so, it may not engage in the "solicitation" of insurance business in Washington.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

1. The activity of the NFRP as described herein is within the jurisdiction of Title 48 RCW and the Insurance Commissioner.

2. The activity of the NFRP as described herein, particularly the mailing of materials such as found in Exhibit 10 and the sale of the resulting "lead cards" to insurers and insurance agents, constitutes the "solicitation" of insurance, a type of "insurance transaction" for which a license is required.

3. Until and unless the NFRP becomes licensed as an insurer, agent, broker, or solicitor, it may not solicit Washington residents to purchase insurance; specifically, until it becomes licensed as one of these four types of entities, it is prohibited from engaging in the conduct described herein.

4. The materials contained in Exhibit 10 and the way in which they are used constitute misleading and deceptive advertising.

This Order is entered pursuant to RCW 34.04.120, RCW 48.04.010, and WAC 10-08-210.

Issued at Olympia, Washington, this 6th day of October, 1989, and effective immediately.

DICK MARQUARDT
Insurance Commissioner

EDWARD H. SOUTHON
Deputy Insurance Commissioner

RICHARD G. (DICK) MARQUARDT
STATE INSURANCE COMMISSIONER

DAVID H. RODGERS
CHIEF DEPUTY

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

REPLY TO:
OLYMPIA OFFICE
INSURANCE BUILDING
OLYMPIA, WASHINGTON 98504
(206) 753-7301

March 2, 1989

NO. D 89 - 56

Christian Association of Retired People
1920 - 116th N.E., Suite 201
P.O. Box 6267
Bellevue, Washington 98008

Attention: Douglas M. Cullen
President

ORDER TO CEASE AND DESIST - Douglas M. Cullen
Christian Association of Retired People

Dear Mr. Cullen:

The enclosed advertisement has been referred to me for review and action. The subject advertisement, lead card and business card of David L. Kinney are attached hereto as Exhibit A and made a part hereof.

By means of the subject advertisement, Christian Association of Retired People is soliciting for insurance in the state of Washington. See RCW 48.07.060. In order to solicit for insurance, the solicitor must be licensed by this office as an insurance agent, broker or solicitor. See RCW 48.17.060. Although you yourself are, in fact, licensed as an insurance agent, you must advertise in your own name and identify yourself as an insurance agent. You may not obtain leads for insurance prospects (i.e. solicit) by means of identifying yourself as President of Christian Association of Retired People. Further, you are not licensed by this office to use the name "Christian Association of Retired People" as a dba.

We note that the telephone number given for Christian Association of Retired People is the telephone number for the insurance agency, M.G.A., Inc. Additionally, the individual who brought this to our attention advises that the business card of David L. Kinney of M.G.A., Inc. was received along with this advertisement and lead card to complete and return. Upon returning the lead card, the recipient was visited by a "young man" who then sold her a senior citizens health insurance policy. Although Mr. Kinney is a licensed insurance agent in Washington, he is not affiliated with M.G.A., Inc. as required by law. Further, you are not affiliated with M.G.A., Inc. either.

EXHIBIT B

Finally, WAC 284-50-050 provides:

> (1) The format and content of an advertisement to which these rules apply shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the insurance commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed
>
> (2) Advertisements shall be truthful and not misleading in fact or in implication. ...

Your use of an unauthorized name, which also carries with it misleading implications and for the reasons specified above, together with your including minimal benefits of membership other than insurance (items 4, 5, 6, 7, 10 and 11 are all solicitations for insurance), the subject advertisement is misleading and deceptive and is in violation of WAC 284-50-050 and RCW 48.30.040 which provides that no person shall knowingly make deceptive or misleading representations or advertising relative to the business of insurance.

You are hereby ordered to immediately stop the dissemination of the subject advertising material. You are also ordered to immediately cease any initial contacts made with any prospective insureds whose names were secured through the use of this or any advertisement utilizing the name Christian Association of Retired People. Further, you are hereby ordered to promptly detail for me 1) the past and current activities of Christian Association of Retired People, 2) the specific manner in which the lead cards obtained through this advertisement is utilized and 3) the function of yourself, David L. Kinney and Duane Tresham.

Your immediate response to the undersigned is expected.

Very truly yours,

DICK MARQUARDT
Insurance Commissioner

PATRICIA D. PETERSEN
Deputy Insurance Commissioner

Attachment

CARP
Christian Association of Retired People
1920 16th NE, Suite 201
Post Office Box 6267
Bellevue, Washington 98008
(206) 62 28 - Tacoma
or
(206) 455-2850

12/15/88 Senate Committee on Health 464-6262
State Comm. in Olympia 753-7300

Dear Friends:

Take a moment to give yourself a small gift that will continue giving you benefits all year long — a membership in CARP. Your Spouse will receive "free" membership with full benefits, when you join CARP. You needn't be retired to join! The only requirement is that you have reached your fiftieth birthday. CARP members enjoy good will and considerations throughout the year. The ten dollar membership offers members many ways to save money on essential goods and services.

1 Wholesale Purchasing Plan
Save up to 40% on first quality merchandise

2 Total Travel Plan Discounts
- Advertised Packages, Cruises, Charters
- Scheduled Airfares

3 Hearing Aid Service
Save 40% to 50% on Name Brands.

4 Long Term Nursing Care
All levels of care in a nursing home. Available to members.

5 Medical Prescriptions
Save 25% to 50%
- First-Quality Name Brands and Generics
- Year-Long Service
- Available Anywhere Through the Mail
- Vitamins and other home care items available at discount prices.

6 Home Health Care Plan
Provides part-time or intermittent home health aide services.

7 Save on Optical Care
- Contact Lenses
- Eyeglass Frames
- Other Services

8 Major Hotel/Motel Discounts

9 Bibles and Related Books
Save up to 30%

10 Now Available Individual & Family Dental Plan
Vision & Hearing Coverage

11 Medicare Supplement
- Guaranteed renewable for life
- Part "B" benefits covered at 100% above Medicare allowable charge
- Pre-existing conditions covered 1st day (no waiting periods).

For a detailed explanation of CARP benefits and services, please complete the enclosed postage paid card and mail it today.

Best Wishes,

Douglas M. Cullen, President

Enclosure (1)

EXHIBIT A

Yes, I want more information about CARP Benefits and Services!

MAIL THIS POSTAGE FREE CARD TODAY

- [ ] 100% Medicare Supplement
- [ ] Nursing Home Insurance
- [ ] Home Health Care
- [ ] Bible Discounts
- [ ] Other

NAME _____ AGE _____

STREET _____

CITY/STATE/ZIP _____

PHONE _____

PLEASE PRINT

Return of this card does NOT obligate you in any way.

RICHARD G. (DICK) MARQUARDT
STATE INSURANCE COMMISSIONER

DAVID H. RODGERS
CHIEF DEPUTY

STATE OF WASHINGTON

REPLY TO
OLYMPIA OFFICE
INSURANCE BUILDING
OLYMPIA, WASHINGTON 98504-0321
753-7300 AREA CODE 206

OFFICE OF
INSURANCE COMMISSIONER

In the Matter of	)	
	)	NO. D 89 - 2
COLONIAL PENN FRANKLIN	)	
INSURANCE COMPANY,	)	ORDER TO CEASE AND DESIST AND
	)	REQUEST FOR CONSENT TO FINE IN LIEU
an Authorized Insurer.	)	OF SUSPENSION OF CERTIFICATE OF
	)	AUTHORITY

To: Colonial Penn Franklin Insurance Company
19th & Market Streets
Philadelphia, PA 19181

The attached advertisement, designated as Exhibit A and made a part hereof, is mailed by Colonial Penn Franklin Insurance Company (hereinafter "Colonial Penn") to residents of the state of Washington who are about to reach their 65th birthday and become Medicare recipients. This advertisement contains violations of Washington statutes and regulations.

First, the advertisement repeatedly, and most prominently, advises the recipient that "Without Colonial Penn's Medicare Supplement II" policy, the recipient is required to pay out-of-pocket $20,790 for "an extended hospital stay." On June 10, 1987, the insurance commissioner issued a Cease and Desist Order against Colonial Penn for this identical deceptive statement which Colonial Penn was broadcasting to Washington residents over the television medium. A copy of this Cease and Desist Order is attached hereto as Exhibit B and made a part hereof. Although Colonial Penn requested a hearing to contest that Order, it withdrew its request prior to the hearing and did cease broadcasting the subject television advertisements as required by the Order. Now, however, fifteen months later, Colonial Penn is disseminating the same deceptive statement in written form.

The statutes and regulations upon which the aforementioned Cease and Desist Order was issued are set forth in that Order. These same statutes and regulations prohibit the use of this same deceptive statement in written form. The advisement that, without Colonial Penn's Medicare Supplement II policy, the recipient is required to pay $20,790 for an extended hospital stay is in fact based upon the Medicare beneficiary staying in the hospital 150 days and is misleading and deceptive in that only approximately 2 Medicare beneficiaries out of 500,000 nationwide actually stay in the hospital for 150 days. The average hospital stay for a Medicare beneficiary in Washington State and elsewhere is approximately 4.5 days.

EXHIBIT C

Thus, this advertisement emphasizes coverage amounts which will virtually never come close to being paid under the advertised policy. (Indeed, Colonial Penn's primary advertising piece, its Medicare Overview and Recommendation, even fails to indicate at all that after the Part A deductible Medicare generally leaves no outstanding out-of-pocket hospital costs for days 1 through 60, which is the length of stay in which the vast majority of medicare recipients fall. Rather, the advertising again emphasizes costs for days 61-90 and 91-150.) RCW 48.30.040 prohibits false, deceptive or misleading advertising. The Washington Disability Insurance advertising Regulation (WAC 284-50-010 through 284-50-230) establishes specific standards for advertisements for insurance of the type herein discussed and prohibits advertising which has the capacity or tendency to mislead or deceive, either by fact or implication. With full knowledge of the illegal nature of its statements, Colonial Penn Franklin Insurance Company has violated both RCW 48.30.040 and WAC 284-50-010 through 284-50-230 in that it has used figures emphasizing amounts of out-of-pocket expense a Medicare beneficiary will virtually never accrue.

Second, the subject written advertisement states:

> 2. PAYS BENEFITS FOR DOCTORS' AND SURGEONS' FEES
> Under Part B, Medicare pays 80% of your allowable charges for most doctors' bills and related medical expenses. Colonial Penn's Medicare Supplement II pays the remaining 20% for you ... a maximum benefit of $100,000, after you satisfy an annual calendar year deductible of $200.

This statement implies that with the Colonial Penn Medicare Supplement II policy the Medicare recipient will now have 100% of doctors' and surgeons' fees paid after a $200 deductible. In fact, statistically, except in the cases where the physician accepts assignment, with the Colonial Penn Medicare Supplement II policy the Medicare recipient will have only approximately 55% of the actual doctors' and surgeons' charges paid. Colonial Penn Franklin Insurance Company has violated RCW 48.30.040, cited above, and the Washington Disability Insurance Advertising Regulation, cited above, in that in order to induce new Medicare recipients to purchase its Medicare supplement policy, it has disseminated advertising which has the capacity or tendency to mislead or deceive either by fact or implication in that it has at least implied that with the Colonial Penn Franklin Insurance Company Medicare Supplement II policy, the Medicare recipient will have 100% of doctors' and surgeons' fees paid when, in fact, statistically only 55% of such actual charges will be paid.

A violation of any of the above referenced rules carries with it severe penalties. Additionally, a violation of WAC 284-50-010 through WAC 284-50-230 is an unfair method of competition and an unfair or deceptive act or practice in the conduct of the business of insurance, pursuant to RCW 48.30.010 and WAC 284-50-210.

The insurance commissioner is most concerned with the manner in which Colonial Penn Franklin Insurance Company is operating its insurance sales and marketing. The Washington advertising regulation which Colonial Penn has violated is and has for some time been in substantially similar form in 48 states and is also virtually identical to the National Association of Insurance Commissioners model regulation. Further, as recently as June 1987 the insurance commissioner issued a Cease and Desist Order against Colonial Penn for exactly the same deceptive representation concerning out-of-pocket costs for hospital stays as is now contained in the current written advertisement. Colonial Penn appears to be continuing its advertising practices in intentional disregard of these well-established laws and regulations. As a result, the insurance commissioner considers it necessary to take action at this time, such as suspension of Colonial Penn's Certificate of Authority to transact the business of insurance in Washington State to cause it to review all of its sales and marketing practices with an awareness of these applicable advertising laws and regulations. In lieu of such a suspension, however, the insurance commissioner will consider Colonial Penn's agreement to his form of order levying a fine of $10,000 and which will include Colonial Penn's consent to correct its improper practices and to comply with Washington laws and regulations which pertain to the marketing and sales of insurance.

PURSUANT TO THE FOREGOING AND RCW 48.30.010, IT IS HEREBY ORDERED:

1. Colonial Penn Franklin Insurance Company and any of its affiliates shall cease and desist from the use of all advertisements and dissemination of information in any form which contains the violations hereinbefore described, or any similar violations, which are received by residents of Washington State.

2. Colonial Penn Franklin Insurance Company shall make a prompt determination concerning whether or not to consent to the insurance commissioner's form of stipulation and fine as hereinbefore described so that the insurance commissioner may proceed promptly with further action if necessary.

OFFICE OF INSURANCE COMMISSIONER

3. This Order shall be mailed to Colonial Penn Franklin Insurance Company registered mail with return receipt requested. This Order is effective immediately.

ISSUED AT OLYMPIA, WASHINGTON, this 6th day of January, 1989.

DICK MARQUARDT
Insurance Commissioner

PATRICIA D. PETERSEN
Deputy Insurance Commissioner

REGISTERED MAIL
NO. 401 601 372

Ms. UNSOELD. Thank you. Mr. Erwin.

STATEMENT OF THOMAS ERWIN, INSURANCE CONSUMER ADVOCATE, OREGON DEPARTMENT OF INSURANCE AND FINANCE, SALEM, OREGON

Mr. ERWIN. Thank you, very much. Congresswoman Unsoeld and Congressman Wyden, thank you very much for the opportunity to be here this morning to speak with you.

I'm Thomas Erwin, I'm the Oregon Insurance Consumer Advocate, and I extend my warm regards and also the congratulations of the Insurance Commissioner from Oregon, Ted Kulongosky, for holding these important hearings on the future of health care for seniors.

Let me be brief—I'm not going to be redundant here and cover the same things that Patricia covered earlier. Obviously Oregon suffers and is in the same situation when it comes to some of the deceptive marketing practices, all of the deceptive marketing practices that occur here in Washington, occur in Oregon. And some of the same unscrupulous sales tactics also occur.

But I would like to address several issues here. The first one being what I see and what I just said last week, and that is the rate increases that may be coming down the pike as a result of the repeal of the catastrophic coverage Act. I know Congressman Wyden is very, very concerned about this issue. He sent a letter to the Insurance Commissioner prior to the rate making hearing last week and which the Commissioner read into the record. And I am concerned as well, testifying against those rate increases, which by the way included not only Medicare supplement policies, but major medical policies.

The average rate increase proposed by Blue Cross in Oregon was 18.1 percent for their Medicare supplement policies, 18.1 percent coming on the heels of what should have been the reduction for most companies as a result of the Medicare Catastrophic Coverage Act.

Unfortunately we didn't see a corresponding reduction on those premiums from all companies. I think the averages were that 30 percent of the companies reduced their premiums, 30 percent held steady and 40 percent probably increased them last year.

Now there's a good reason for that, obviously. It's the reason that everybody's talking about in health insurance no matter if it applies to seniors or of any age group, and that's the rising cost of health care. That's the excuse that's given. That is the reason it is given. Some of it is legitimate. Our concern, of course, is that we do not want the repeal of the Catastrophic Coverage Act to be a burden or an excuse on the backs of Medicare supplement recipients for raising the premiums at such a level that they exceed what is justifiable.

And I'm hoping when the insurance commissioner rules on that particular rate increase, by the way, that he makes that same decision. I realize that health care costs are going up, but I'm hoping that the increase will be appropriate.

I want to also talk about what all of this means in the private insurance market, because some of those benefits that Medicare

Catastrophic Coverage Act was going to cover will now be captured within the private market, presumably. And should the premiums reflect the 1988 rate? Obviously again allowing for medical inflationary costs, they should.

The Federal Government's General Accounting Office, and you're well aware of this information, recently completed a study indicating that the Medicare supplemental premiums will increase to an average of $69.35 per month because of repeal. My concern, like yours, is that those increases reflect accurately the cost of coverage and are not used as an excuse to increase premiums.

The problem is of course, is that many people will face an increasing burden and those that will are probably the least likely to afford it in the first place. Those who probably are most at risk because of their living conditions and because of the income levels that they are at, are probably going to be the ones that suffer the most. They are less likely to have Medicare supplement in the first place and many of them will choose to go without, because of the increases in premiums, and that is abhorrent and unacceptable.

Obviously the States regulate this, not the Federal Government when it comes to private carriers and their premiums, but it's a fact and I know Patricia will support me on this, that given the broad spectrum of resources designated to State Insurance Division budgets, it is simply a hodge podge of regulatory scrutiny. There is simply not consistent scrutiny out there. State by State it is very, very different and some States designate a tremendous amount of resources and I think Washington is lucky because they do designate so many resources.

To give you a comparison or an idea of the difference or distinction between Washington and Oregon, and not to embarrass my State at all, but the fact is that the State of Oregon's SHIBA program began in about 1980 or 1981, it lasted for 9 months, and because of the recession it was a product of the budgetary cuts that were made at that time.

Under the Consumer Advocacy Program that I began back 2 years ago when I was first hired in this new program, I wanted to see a SHIBA like program exist in Oregon. And I went to the State of Washington and spoke with the Insurance Commissioner's representatives up there and talked about what we could do to implement that in Oregon. But the fact is that it takes a great deal of money.

In that regard, I'm disappointed to see the Catastrophic Coverage Act repealed because there were designated funds for a demonstration project under Section 424 that would have helped assist consumers in certain areas of the country to get the kind of education that they need to make the correct decisions that they need to make. To give them the tools to decide what is the best in terms of their own needs, to make choices about the many, many Medicare supplemental policies that exist out there.

Insurance Consumer Advocacy developed a consumer guide for Medicare supplement insurance that represents about 70 companies of about 118 companies that are selling policies in the State of Oregon. There's only 70 here because they probably represent the most popular ones and the greatest share of the premium market. And obviously with the limited budget we have, we had to make

cuts somewhere. It's the kind of thing, however, that consumers are demanding greatly. That they need. I don't want to see it be used by the agent sales force, which unfortunately is always a problem because they use it to compare policies to sell what they think is a better policy. But I think it can be used by a SHIBA type program and by people who are trained to look at the policies and make comparisons and not to give advice as to which policy is best for that particular individual, but to give them the tools to make their own decision about which choice is best.

That's the kind of thing I would like to see the Federal Government play a bigger part in. I realize we're talking about a limited amount of resources for the Federal Government as well as the State Government. But it's the kind of thing that we need to address.

Two other really quick issues here. One of course, beyond education we need to talk about the duplication problem. And again Congressman Wyden and I'm sure Congresswoman Unsoeld are both very concerned about this. Oregon recently enacted a bill that I had submitted to the Legislature, Senate Bill 190, which requires the agent to fill out an acknowledgment form as to what other existing coverage may be there and to see whether or not that is duplicative or not. The policy holder, the prospective policy holder before making the purchase, would also sign that to acknowledge that the comparison has been made.

I think while it isn't going to be the answer, it is not a panacea for this issue, it is one of those things that can offer a tremendous help and a tremendous resource for the consumer, who doesn't always know what they're purchasing and often makes duplicate coverages. And in a sense, in my way of thinking and most consumer advocates' way of thinking, is wasting money by doing that.

Finally, I would like to talk about long-term care for just a minute. Oregon just recently went through a long process of about a year. The Governor's Commission on Long-Term Care Financing, on which I was a consultant, came up with a number of recommendations. But Oregon again is behind Washington in passing legislation that would have an impact on that particular private insurance market. We did pass legislation this last legislative session that gives us the kinds of consumer protection that we really need to see in this area, because in the past Oregon was simply almost totally unregulated.

Now we require that no policies can be offered which have a prior hospitalization requirement, for example. I don't know for certain, but it's my understanding if we repealed the Catastrophic Coverage Act, we may be going back to what was previously there in terms of the prior hospitalization requirement for the skilled nursing portion. And maybe one of you can correct me, but that's my impression of what's happened.

That is abhorrent because what we're doing effectively is preventing 60 percent of those people who have bought that coverage, or under that coverage, and we've excluded them from that particular "benefit." And to have the private market suddenly change and the Federal market in a sense is what I'll refer to it as, go backwards in that area, is abominable.

I would also like to suggest that there were a number of benefits, albeit the financing mechanism is what everybody complained about. There are a number of benefits, the mammography benefit was mentioned, the hospice care benefit and respite care benefit that Congressman Wyden was so essential in enacting, are very important benefits that every senior that I've talked to would like to see somewhere. And obviously it's a judgment call and I'm glad to see that the two of you are not gun-shy, as I've heard rumors about Congress generally being on this issue. That you still see the need for there to be some kind of legislation to address the needs of seniors in health care insurance and that it not be financed solely on the back of seniors.

Thank you, very much.

[The prepared statement of Mr. Erwin follows:]

NEIL GOLDSCHMIDT
GOVERNOR

Department of Insurance and Finance

21 LABOR AND INDUSTRIES BUILDING • SALEM, OREGON 97310

Testimony of Thomas B. Erwin
Oregon Insurance Consumer Advocate

to the

United States House of Representatives
Subcommittee on Housing and Consumer Interests

December 4, 1989
Vancouver, Washington

Thank you very much Congresswoman Unsoeld and Congressman Wyden for the invitation and opportunity to speak with you this morning regarding "The Future of Health Care for Seniors: Where Do we Go From Here?"

Obviously, from my standpoint, I share the same concerns as each of you do regarding the private health care market and whether or not it is a visible option for seniors.

Let me address first of all, the ramifications of repeal of the Medicare Catastrophic Coverage Act and what that might mean for seniors.

We recently had a rate making hearing in Oregon regarding Blue Cross Blue Shields proposed rate increase which <u>averaged</u> 18.1 percent for their Medicare Supplement products.

That particular rate increase proposal can be analyzed in two components. The first component is that portion required to compensate for increased health costs, increased utilization and past deficiencies because of possible underpricing (which may have occurred as long as 4 to 5 years previously).

The second component is that portion resulting from repeal of the Catastrophic Coverage Act. As you know, while repeal of the Act means that the $4.00 per month add-on charges in Medicare Part B premiums will be eliminated January 1, 1990, the adjustable premium still will increase to $28.60. Under the Act this year, the premium is $31.90. The surtax is also eliminated which is what a great many seniors were complaining about and felt was unfair.

The result is that the increased benefits that catastrophic coverage provided this year will be gone, too. Among them: unlimited hospitalization (with only one deductible payment per calendar year), and hospice and respite care benefits. Additional benefits to be phased in later are also repealed - including mammography screening, a limit on a person's out-of-pocket expenses, and expanded drug prescription coverage.

What all of this means is that the private insurance market will now try to capture some of those benefits in their policies, but at the very least, return to what kind of coverage was being offered prior to enactment of the Catastrophic Coverage Act (back to 1988 coverages).

Should the premiums reflect that 1988 rate? Yes, they should while allowing for increases in medical inflationary costs over the past year.

What we do no want to see - and I know Congressman Wyden is very concerned about this issue (as I am sure Congresswoman Unsoeld is, as well) is to use the repeal of the Catastrophic

Coverage Act as an excuse to increase premiums! That would be a travesty and tragic for many, many individuals. I pledge that I will do all that I can to make certain that does not happen in Oregon.

The Federal Governments General Accounting Office has indicated in a study they recently completed, that premiums on Medicare supplement policies will increase to an average $69.35/month because of repeal.

My concern, like yours, is that those increases reflect accurately the cost of coverage, and are not being carried on the backs of people to increase profits.

Lower income beneficiaries will now have to pay for more of the costs than they would have, had the Act not been repealed. This puts an increasing burden on those who can least afford to pay, and those who probably are most at risk because of the living conditions they must suffer.

They are less likely to have Medicare supplement policies in the first place, and many of them will choose to go without coverage because of increases in premiums. This is abhorrent and unacceptable.

But what this may mean also, is that we are witnessing the dissolution, and possible collapse of the health care delivery and financing system in this country.

As was indicated in prior testimony, health care costs are out of control, and the federal government is shifting enormous costs from their programs (Medicare and Medicaid) to private payers, in part to meet Grammm-Rudman targets. In addition, further cost-shifting occurs when private payers are forced to drop their coverage and are squeezed out of the system because of the uncontrolled health care costs and premium increases.

They are then made part of that group known as the "uninsurables" - because of their pre-existing conditions they may simply be unable to afford insurance coverage at all.

There are other issues which need to be addressed:

1. Non-Duplication Protection
   a. Twisting or replacement
   b. pre-existing conditions limitations. Oregon's response: SB 190 - acknowledgment form

2. Long-term care
   Medicare Catastrophic Coverage repeal means reinstatement of prior hospitalization requirement that effectively excludes 60% of the population from skilled nursing home care.

3. Education
   a. Clean sheeting
   b. Cold lead cards
   c. Celebrity advertising and other deceptive advertising
   d. SHIBA (Senior Health Insurance Benefit Advisors)
   e. Demonstration project (elimination of Sec. 424 from Medicare Catastrophic Coverage Act)

One of the tragedies of repeal of the Catastrophic Coverage Act is the elimination of Section 424, entitled "Benefits Counseling and Assistance Demonstration Project for Certain Medicare and Medicaid Beneficiaries." It authorized the Secretary of Health and Human Services to establish a demonstration project for the "purpose of providing training and technical assistance to prepare volunteers to provide elderly individuals receiving benefits under title XVIII (18) or XIX (19) of the Social Security Act counseling with respect to the Social Security Act Counseling with respect to

eligibility for such benefits and assistance in preparing such documentation as may be required to fully receive such benefits."

It is abhorrent to me, that the Federal Government does not provide money for such programs, given the fact that confusion reigns supreme in the medicare supplement market. Now admittedly, the Federal government has thus far chosen to continue to allow the states to regulate the private insurance market, but because most state insurance divisions are seriously underfunded, they simply do not have the resources to provide the kind of training and information necessary to empower consumers to make the best choices possible to meet their individual needs.

I believe it is the federal government's responsibility to provide some of those resources especially given the fact that they are responsible for creating even more of the confusion surrounding Medicare supplement policies due to first, the enactment of the Catastrophic Act and, now its repeal.

The State of Washington has had its very successful Senior Health Insurance Benefit Advisor (SHIBA) program for at least 13 years, and Oregon is behind in responding to that need, although I am happy to announce, we just awarded a 20 month grant of $25,000 to have training workshops for such a program.

However, education of consumers to help assist them in identifying their individual needs, and to help them identify which companies they should choose to buy policies from, is the responsibility of both the federal government and state government.

Thank you very much for the privilege to speak with you this morning; I would be glad to answer any questions you may have.

Ms. UNSOELD. Thank you. Before asking questions, I want to put in a plug at this point, because we've had some advocates today who came from some local and community government entities. We have representatives of the so called Faceless Bureaucracy of Government, but you can see that they are fighting on behalf of the people in their States. And I'd also like to introduce the staff that we have here in case any of you who have held out here to the end want to pounce on them, because they are also tremendous assets to all of you and to us in helping to work on these problems, in particular Brian Lindberg, where are you, stand up. He is the staff director for the committee. And David Dean, who is on the professional staff, both here from Washington D.C. to help us today. And from my own staff, Paul Elliott who is from Washington D.C., and Donna Levin who is from the Vancouver office here working on these issues and I believe it's Liz Price, from Representative Wyden's office. So those of you who have stayed, you have a number of us to pounce on when we are through.

I would like to ask a couple of questions, however, before our time totally runs out. And I really appreciated the testimony from the two of you. But what happens when the cease and desist orders are violated? What can you do next? Do you have enough teeth? Are there things that the Congress should do also to help you enforce that?

Ms. PETERSEN. It is interesting you should mention that because my first—I've issued orders against 15 lead companies and I've just had my first challenge. Either they ignore it and just figure we don't have authority, or they actually stop. I mean and normally our licensees, the insurance companies and agents make—they're very careful to comply with orders from the insurance commissioner's office. These companies are different and the challenge concerned our authority and we did prevail on that at the administrative level. It's very tenuous and actually Exhibit A is the opinion where the judge decided that we had authority. But it's very tenuous. It's a lengthy procedure because they're not licensed insurance agents or companies.

I do my best to find out who they're selling them to, the lead cards, what company or agent they're selling them to and I can stop it at the source of funds for a lead company. But in that particular hearing under oath and also by subpoena, I asked that company what insurance companies they were working for, of course intending then to tell the company that they couldn't buy these cards and they couldn't utilize this service because it was completely illegal. He swore that he didn't know what companies or agents were paying him, were doing business with him essentially.

It's a great problem. And actually in the draft of the NAIC Consumer Protection draft that is no longer under consideration, it was completely withdrawn and essentially—but that did give the State specific authority over insurance companies, agents and entities representing insurance companies or agents. So some wording like that in the law would be very good for us, because again most States have determined that they have no authority to do anything.

And the problem is that the agents, once they buy the cards they just show up at the person's house. I don't know of any situation

where an agent has even called an insurer for an appointment and the person never even knew they asked for insurance.

So, I have a citizen administrative law judge and lots of our abuses come up through somebody just opening their door and here there is an insurance agent there they take them essentially unaware.

So, that would be wonderful. I can submit some suggested wording, actually that was from—

Ms. UNSOELD. That was going to be my next question.

Ms. PETERSEN. Yes. Because technically I think there is a good argument for us having no authority unless we can pinch it off at the source and just go for the insurance company.

Ms. UNSOELD. I would also like to ask you, Patricia, if I could get a copy in the future of your 1987 testimony?

Ms. PETERSEN. Yes. I'm leaving a copy here.

Ms. UNSOELD. Okay, thank you. Representative Wyden.

Mr. WYDEN. Well, all of you are just doing a great job in your two offices. Ms. Petersen, we haven't had a chance to meet,—

Ms. PETERSEN. No,—

Mr. WYDEN. —but I can see you obviously feel strongly about these issues. And Tom Erwin has just been doing a tremendous job as an advocate in the Oregon Insurance Commissioner's Office as well.

Let me ask you just a few questions—this is a terribly important topic and we probably ought to spend hours trying to focus on it.

My sense is that this current environment where catastrophic coverage has been repealed—we're already seeing signs of rate hikes—is absolutely tailor-made for the rip-off artists, the people who could come in, and take advantage of the confusion and exploit older people. Do you all share that view?

Mr. ERWIN. Sure.

Mr. WYDEN. We've got to get this on the record. Ms. Petersen, do you share that view?

Ms. PETERSEN. Clearly that's the case. This is the most, the most abused market in insurance in the country that I can see, at least in our State, is the elderly health insurance market.

Mr. WYDEN. But at this time in particular, the next few months I guess is what I'm trying to ascertain. My sense is this is an ideal time for the rip-off artist to come back and go after older people. Mr. Erwin?

Mr. ERWIN. You're absolutely correct, Congressman Wyden. It's an opportune time for those companies who would use this as an excuse. It's going to require a great deal of scrutiny on the part of the insurance regulatory process, on the part of every State. The danger of course is, given the limited resources that many of those States have, is they simply won't be able to keep the rates down and have them justified for—we're all going to see rate increases, as you well know, and it's just making sure that they're justifiable.

Mr. WYDEN. Now, there is no question that there are good insurance companies and there are good agents. Just no question about it. But could you all give us some indication of how many fit the other category? How many do you think raise serious questions in terms of unscrupulous practices? Are we talking about 10 percent,

20 percent, what sort of numbers numerically do we have to be concerned about in terms of those that we better keep our eyes on?

Ms. PETERSEN. Well, that's a hard question to answer. I think it is a minority, but it does not—it is not limited to small companies. Major companies we've had as much trouble with—major national companies as small fringe companies. I mean there's not—so essentially if you go to a major one, it does not by any circumstances mean that you're to avoid this problem. But I do think probably of all of our companies it would probably be a minority, but it's prevalent.

Mr. WYDEN. More than a handful?

Ms. PETERSEN. Yes, definitely.

Mr. WYDEN. Mr. Erwin, any sense?

Mr. ERWIN. Well, my sense is it is probably less than 10 percent that you're talking about in terms of purposely taking advantage of the consumer. Now, there are those who inadvertently or through their own incompetence, and quite frankly sometimes the agents don't know as much about their policies, or the companies don't train them sufficiently to know as much about their policies as they should know. So if you're talking about maliciously going after a consumer, I think you're probably talking about less than 10 percent.

The problem is there are many consumers, many seniors in particular, who will not complain if they think they've been taken advantage of because they're maybe perhaps embarrassed that they've been taken advantage of and you get those people who simply don't know that they were taken advantage of. And so the problem exists inordinately out there and if we had more resources, and the more resources you have the more you advertising the services of an insurance division the more calls are coming in, the more you make everybody aware of what they can and are able to do.

Mr. WYDEN. Both of you had made the point, and it's a good one, in terms of duplicate coverage and it's something I want to ask some other questions about on. But do you have any information with respect to Oregon and Washington with some evidence of how many seniors in Oregon and Washington have two or more policies? Do either of you have some information on that?

Ms. PETERSEN. No, I don't think we keep records that way. But also I think Tom makes a good point and that is that only a fraction of the seniors who have problems come to our office. They are either—if I were a senior and I were covered by a company and had a problem I probably would be frightened to make a complaint, because I would think that they would take some other kind of action against me possibly. I've had many witnesses frightened to appear at a hearing against an agent that they've had problems with because of the same types of reasons. I don't think we would be able to find any information about the numbers on that.

Mr. WYDEN. But it is common that older people often have multiple policies and sometimes it's still more than 2, sometimes it's 3, 4 and up.

Ms. PETERSEN. Right. There was a case in California actually that was just won by the, not by the insurance commissioner's office, it was by the district attorney for Santa Cruz County, and in

that case it was against a large agent and also a major company. And some of the witnesses had 9 policies. But our State, we don't see that too often, but we see duplicative, more than two.

Mr. ERWIN. Two little comments, Congressman. One is that when I first started my job I started looking through the complaint files and talking to compliance officers about how much the problem existed, to what extent. And the worst case scenario was this woman who was 83 years old and had 30 policies, primarily Medicare supplemental policies. I mean that's absolutely outrageous and egregious, obviously a woman of some financial means, but also somewhat disorientated not knowing what she was doing.

The Insurance Division in the State of Oregon, by the way, took action and was able to have $23,000 worth of premiums returned to that woman the last time I looked into that particular case.

But I also read a study prior to the Senate Bill 190's introduction into the Oregon State Legislature this last session from the Health Insurance Association of America, and they are the ones that are industry-oriented who said that they estimated 40 percent of the Medicare supplemental market consisted of duplicate policies, duplicate coverage, which is a phenomenal figure to me. I mean I wouldn't have thought it was that large, but that's what they were saying from their studies that they had done, it was around 40 percent had duplicate coverage.

Mr. WYDEN. I have not seen a number that high, but certainly we hear very frequently quoted 25 percent of two or more and I appreciate you all making the point that the vast majority of experts say that one should try to get one good policy.

Ms. PETERSEN. I think the Federal law in that too is, and I'm quite sure if this stayed or went with the repeal, but the Federal law does not say it's illegally duplicative if there is not a coordination of benefit provision there, so if it does pay you double then you can—then it's not duplicative prohibitatively, which is not sensible for consumers even that way.

Mr. WYDEN. Three cheers for you, because what I was going to ask you about now was is the Federal law on duplication. One of my priorities this upcoming year is going to be changing that statute, Section 1882 of the Social Security Act, and I wanted to go through a couple of parts with you.

Now, the first part that seems to me to be a major loop-hole, is the way that the current law stipulates that there would be no penalties, civil or criminal, if the policy sold is not "substantially" duplicative. It uses the words substantial duplication, but nowhere does it define "substantial" duplication. Would it be sensible to eliminate that loop-hole in Section 1882?

Mr. ERWIN. Oh, I think absolutely. I mean no agent, you know, talks about what that means and to the policy holder, that's for sure, what is substantial duplication. And if it's not defined, then who's going to be able to judge it.

Ms. PETERSEN. Or litigate it.

Mr. WYDEN. Or litigate it, okay. The second one I wanted to talk about is the important point you make, Ms. Petersen, with respect to the other major—well, there are really 3 huge loop-holes in the current statute. I think that it is more loop-hole than law at this point. But what you're saying is that under the Federal law you

can sell as many policies as you want as long as they all pay out something and your view is that this results in a lot of older people not getting their monies worth.

Ms. PETERSEN. Yes, correct. That's correct, Congressman. I think that financially that is not sound—it's still not sound to buy a Medigap policy even though it does not—even though it would pay some, you would get double payment in some occasions. I think that there are 2 problems, economically you still have got to pay the premium, and number 2, some companies probably do administer it with coordination benefit in fact, even though that's not provided for in the law—because they administer other group policies in the State with coordination benefits.

Mr. WYDEN. At this point, when you bring an action against duplication or when you're going after the outrageous practices in Oregon and Washington, you're primarily relying on your State statutes right now, because the Federal one has these loop-holes. Is that correct?

Ms. PETERSEN. We really don't have a specific rule that's enforceable on duplicate policies. That's something that we just haven't administered. There is some sentiment, of course the companies will write back and say they can buy as many as they want, it's a free country and all that. So we have not taken action against that type of sales too much, although we should.

Mr. WYDEN. And it would be helpful to you, as Mr. Erwin said, to have a strong Federal law as it relates to duplication?

Ms. PETERSEN. Yes, absolutely, yes.

Mr. WYDEN. We'll, we're going to want to talk with you all a lot on that, because I mean as you've made mention, the rates are going to go through the stratosphere next year and I want to ask a question on that as well. But at the very least the Federal Government ought to be moving to go after these duplicative policies. People thought they had done this years ago with the Baucus legislation but it's mostly just voluntary and a "good housekeeping seal of approval" and all this kind of thing, and I'm glad we've got some hard-nosed people out there like yourselves.

Now, on this rate issue, if we go back to the pre-catastrophic period, wouldn't it make sense to say, as a general rule, that Medigap rates should go back to pre-catastrophic levels, plus an adjustment for inflation since that period, and that's it, unless there are extenuating circumstances. Mr. Erwin.

Mr. ERWIN. I absolutely agree with you; in fact that was the nature of my testimony at this rate hearing last week.

Mr. WYDEN. Ms. Petersen.

Ms. PETERSEN. I think that that has a lot of truth to it. We saw when the Catastrophic Care Act passed we saw rate filings go approximately one third rate increase, even so, one third decreased and one third stayed the same. So, now with the advent of the repeal the rates should be focused on what was reasonable beforehand.

Mr. WYDEN. Two others. You mentioned the matter of mail order and I get the feeling that that is still a very serious problem that as we get into the Medigap area this upcoming session, ought to be a subject of Federal focus, because there it's interstate and someone is pumping this mail out from some PO box somewhere in

some State and sending it all to Oregon or Olympia or wherever. Would it be your view that this should be another area, you know, mail order abuses that we ought to be looking at in terms of Federal involvement in Medigap?

Ms. PETERSEN. I think we need something specific giving us authority. I think that we do—we have a major problem here that has not going away. I have spent a lot of time in this area and it just simply has not gone away for all these years. And we found, in fact, we found some clear indications of substantial Federal tax fraud in the one case where I was able to subpoena the documents. I mean a man and his wife made $500,000 in income in one year because it operated in 6 States and he paid $2,000 in income tax and we went into why and all this and I mean these companies are not regulated by anybody. And they do come out of Texas primarily and Texas has not taken action against any of them although they have identified 72 such companies operating in Texas, they have not taken action.

So the source is not nipped in the bud there and we do have problems. A piecemeal does not work in many marketing situations. It simply does not work State by State, it does not work in that area. Television broadcasts might be similar.

Mr. ERWIN. Let me also respond to that if I may. I know we're running short on time. Oregon has faced the same situation. They issued a cease and desist order back in 1987 against a company called ASCA, and I noticed that Patricia has it here as well. The company, all they did is put another PO box with a different, actually it was a Washington D.C. address the last time we looked at it, but it's the same executive director and president of the company who still lives in Texas and the same scam is going on now in 1989. What they do, of course the envelopes look very official, it either says "Second Notice," it says, "Social Security Update," or it says "Affiliated with Any Government Agency" and they leave that "not affiliated with any Government Agency" off of it, you know, simply a typo or whatever. So the person that gets it thinks it's a very official-looking document related to the Federal Government, related to Medicare. And I would think that Congress would have a—play a very important role in hopefully trying to regulate something like that and giving us some teeth in which we can go after these companies. Because as Patricia mentioned, it's tenuous given the statutes that exist State by State as to how to go about getting to them if they're transacting insurance or not.

Now, I think we can make the point that they are. We did issue another cease and desist order and we are going into Court about it, because they're simply flaunting their nose and saying we don't have to comply with the statute.

Mr. WYDEN. I think you both make a very good case on mail order. And that's one where I think Congress—Congress feels there isn't a problem, you know, today and you—

Ms. PETERSEN. Yes. Actually it's interesting because I've gotten called from another committee that has regulatory authority over the FTC and their staff director was—this was maybe 4 or 5 months ago—and their staff director was saying, well, the FTC is telling us that there is not a problem with those mailings; gosh, there just aren't any. And I was able to pull out a few letters.

What they do is send them to the States, because I've gotten at least a couple from, I think, a couple of our Senators have gotten complaints and they've sent them onto the FTC who just sends them on with a form letter to us. Maybe that's why they have not—they don't have an active division there, because we really do get them. We get referrals from HCFA regularly on marketing. We get FTC referrals and I just find it real interesting that they don't think that there is a problem.

The U. S. Postmaster, I don't know whether they handle those or not. I know the Commissioner in Washington D.C. says she sends them to the Postmaster, but I don't know exactly what they do with them. Essentially it's handled by the States.

Mr. WYDEN. Did you get some information in writing from the FTC on this?

Ms. PETERSEN. Yes.

Mr. WYDEN. If you could get that to Congresswoman Unsoeld—

Ms. PETERSEN. Sure, I'd be happy to.

Mr. WYDEN. —and that would be very helpful.

Ms. PETERSEN. All right. I'd be happy to, yes. It's a huge market, huge profits and it's very very destructive for seniors. I mean this mail order business is completely out of hand. And I don't mean to say we're probably even making a dent in it.

Mr. WYDEN. One last question on this. Are you finding problems with indemnity policies as well? Policies that aren't classified so-called Medicare supplements, but which pay a specified dollar amount, sometimes adjusted for inflation for a variety of medical services and then they pay other miscellaneous expenses such as parking or care for your pets or something like that? The General Accounting Office has been very critical of these indemnity policies. Have you found problems in your two areas in indemnity coverage?

Ms. PETERSEN. We have hospital indemnity programs that pay maybe $50 a day and also cancer program policies now are pretty popular. Those can be called supplemental to Medicare, but they can't be called a Medicare supplement. So, that is actually being sold and people don't know the difference. I mean there is not—who wants to read all the boiler plate and that's where you'll find the differences, of course.

There—I would say that we do have a problem with that and we need to do something internally with a more clear stamp or something, I think. But I think that the Federal law, of course, could be stronger. I mean supplemental to Medicare is ridiculous to be able to call it.

Mr. WYDEN. I think it's a major loop-hole that you can buy all these indemnity policies and you know, in the effort at the end of the year I was in particular trying to go after duplication, go after the indemnity policies and the more I learned about it the more convinced I am that a lot of this was just larding on extra coverage that people didn't need. Tom, do you want to add anything?

Mr. ERWIN. No, I have nothing to add, except the State of Oregon faces the same thing and I think it was set up exactly the same way.

Mr. WYDEN. Well, we're going to want to work real closely with you because I think that the next few months is going to be a com-

bination of premium shock and a great deal of confusion that is going to make just an ideal opportunity for questionable operators to move. And I know you all are on the front lines trying to tackle this day to day and get the calls and get the concern. And Congresswoman Unsoeld and I will just be trying to help and assist, and thanks for all the work you're doing.

Ms. UNSOELD. I want to thank also Channel 40 CVTV for its coverage so that it was possible for many people in this district to be able to participate without actually being here.

I want to thank my colleague, Representative Ron Wyden, for helping to make this possible.

Particularly thank all of you who have stuck it out to the end. And as so often happens with these kinds of hearings we get a lot of work assignments from the people we work for. And so now it is up to the staff and us to get to work on the many topics and specific issues for which you've given us a work assignment for.

So, thank you very much for your participation today. Thank you.

[Whereupon, at 12:20 p.m., the hearing was adjourned.]

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